



REQUESTS FOR PROPOSALS
RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF COMMUNITY AND FAMILY HEALTH AND EQUITY
INFANT TODDLER HOME VISITING PROGRAM

Certification Standards

TITLE: Maternal and Child Home Visiting Program

The Rhode Island Department of Health (HEALTH), Perinatal and Early Childhood Team within the Division of Community, Family Health and Equity has made funding available to qualified vendors to support expansion of the Infant and Toddler Home Visiting Program to include evidence based home visiting, which will be provided to pregnant women and children up to age 3 years of age by community based nonprofit agencies. The initial contract period will be for a period of 12 months. HEALTH reserves the right to renew awards on an annual basis for up to four (4) additional 12-month periods depending on successful performance and availability of funding. These Certification Standards provide interested applicants with information to assist in their preparation.

Submission Deadline:

4:00 p.m. on Friday, January 18, 2013

to:

Kristine Campagna
Rhode Island Department of Health
Division of Community and Family Health and Equity
Three Capitol Hill, Room 302
Providence, RI 02908

All applicants submitting a proposal are encouraged to attend an informational meeting for those pursuing certification applications to be held on:

Friday, December 14, 2012, from 11:30 a.m. to 1:00 p.m.
at the Rhode Island Department of Health, Beck Conference Room, Lower Level

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SECTION 1: INTRODUCTION

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Department of Health, is soliciting proposals from qualified community based nonprofit agencies to provide expansion of the Infant and Toddler Home Visiting Program to include evidence-based home visiting , which will be provided to pregnant women and children up to age 3 years of age for the Rhode Island Department of Health in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at www.purchasing.ri.us. The initial contract period will begin approximately May 1, 2013. Contracts may be renewed for up to four additional 12-month periods based on vendor performance and the availability of funds.

1. Introduction and Background

Rhode Island has long given careful attention to the health and developmental needs of its young children. Many Rhode Island children experience multiple risk factors for poor development including living in poverty, living in neighborhoods with high rates of crime, living in households headed by a single parent, and living with mothers who have low levels of education. Moreover, evidence shows that living with such risk factors also contributes to an increasing number of very young children who are at risk for abuse and neglect.

Goals of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

The goals of the MIECHV Program are to:

- 1: Strengthen and improve the programs and activities carried out under Title V.
- 2: Improve coordination of services for at-risk communities.
- 3: Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

A number of evidence based home visiting programs have demonstrated that they can reduce negative outcomes for children and families. Through MIECHV, the Rhode Island Department of Health (HEALTH) received funding to provide three evidence based home visiting programs: Healthy Families America (HFA), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). The evidence based home visiting programs funded through MIECHV will work with all other home visiting programs in the funded communities, and statewide, to provide comprehensive services to families at greatest risk for negative outcomes. A rigorous evaluation of MIECHV will also be part of the implementation of the evidence based home visiting program in Rhode Island. These certification standards provide funding for HFA services for up to 25 families in West Warwick and PAT services for up to 72 families in Providence.

2. Certification Process

To be eligible to provide evidence based home visiting services through the MIECHV Program and for reimbursement for services, the provider must be certified by HEALTH. HEALTH, with the national developers of HFA and PAT, has defined a set of standards both specific to each model and across all MIECHV programs in Rhode Island to ensure compliance with federal and state regulations, specific model fidelity, and to ensure the provision of quality services to families with young children in designated communities in Rhode Island. This certification process and the issuance of these Certification Standards provide the basis for HEALTH's determination of providers eligible to provide services and receive payment for services. These Certification Standards establish the procedures and requirements for the MIECHV Program, as administered by HEALTH. These Certification Standards provide potential applicants, service providers and other interested parties with a full description of MIECHV services, including guidance related to certification requirements, methods for application, and evaluation requirements. Satisfactory compliance with these requirements, as well as the requirements for each evidence based model being implemented must be demonstrated and maintained for certification; continuing compliance is required in order to maintain full certification status.

HEALTH will certify one (1) agency to become certified as a provider of HFA services in West Warwick and up to three (3) agencies to become certified as a provider of PAT services in Providence. It is allowable for an agency to submit an application to provide both PAT and HFA services, only PAT services, or only HFA services. Community-based, public or non-profit agencies that are in good standing with the federal government and the state of Rhode Island may submit an application for certification.

It is anticipated that the first year of the project will begin on May 1, 2013. The initial award will be for 12 months, after that contracts will be renewed on an annual basis for additional years, up to 4 years, on one year terms, subject to federal and state requirements, contractor performance, compliance with the terms and conditions of the contract, and availability of funds.

2.1 Submission of Certification Application

Potential applicants must submit applications for certification to HEALTH by 4:00 p.m. on Friday, December 21, 2012. Please submit one original and 5 copies of the application to:

Kristine Campagna
Home Visiting Program
Division of Community, Family Health and Equity
Rhode Island Department of Health, Room 302
Providence, Rhode Island 02908
Phone: (401) 222-5949
Kristine.Campagna@health.ri.gov

Providers will be notified of their certification status when the review is complete. Applicants should anticipate a minimum of four weeks for the review process. The State reserves the right to amend the Certification Standards with reasonable notice to participating certified providers and other interested parties. Once certified, agencies will be expected to reapply for certification through HEALTH every three years.

All MIECHV Program applicants will be evaluated on the basis of written materials submitted to HEALTH, in accordance with the Certification Standards. HEALTH reserves the right to conduct on-site reviews and to seek additional clarifications prior to final scoring.

2.2 Instructions and Notifications to Applicants

This document describes the Certification Standards for MIECHV Program providers in the designated communities. In accepting certification from HEALTH, agencies certified through the MIECHV Program agree to comply with these Certification Standards as presently issued and/or as amended by HEALTH, with reasonable notice to providers.

Within these Certification Standards, specific program requirements, performance standards, mandated benchmarks and expectations are identified. Applications should demonstrate the agency's understanding of each evidence based home visiting model they are applying to provide, as well as their understanding of how they will deliver services with model fidelity, engage the communities where services are being provided and integrate programs into a system of support for families within communities. Applications must include a description of the agency's capacity to carry out the program(s), and must address each required component of the standards. Applicants must describe their capacity to meet the performance standards, participate in a continuous quality improvement plan and their plan to improve health and developmental outcomes by meeting the mandated benchmarks. Applicants should use the evaluation criteria in Appendix 1 as a guide in developing their applications; this is the criteria on which the applications will be evaluated. Applicants are required to submit a W-9 form with their applications. Applications will be scored on the basis of responses to each of the sections in these standards. Applications should be limited to 30 pages excluding attachments and required resumes or cover letters. Incomplete applications will be returned without further review.

Applicants are advised that all materials submitted to the State for consideration in response to these Certification Standards may be considered to be Public Records as defined in Title 38 Chapter 2 of the Rhode Island General Laws, without exception.

2.3 Information for Interested Parties

Upon initial release of these Certification Standards, HEALTH staff will hold one public informational meeting for those pursuing certification applications on (Friday, November 9, 2012, from 11:30 AM to 1:00 PM at the Rhode Island Department of Health in the Beck Conference Room (Lower Level).

2.4 Model Specific Certification Requirements (Additional detail in Appendices 4-6)

An agency that becomes certified as a provider of HFA will also have to submit a separate Application for Affiliation directly to HFA. The ability to provide HFA is dependent upon being certified by HEALTH as a provider of HFA and the direct approval of HFA. In addition, certified providers of HFA must complete the accreditation process, a separate process, for the first time within three years of affiliation. After the initial accreditation, providers then go through the accreditation process again every four years.

All applicants certified as a provider of PAT will also have to submit a Readiness Reflection and subsequent Affiliation Plan directly to PAT for approval. The ability to provide PAT is dependent upon being certified by HEALTH as a provider of PAT and the direct approval of PAT. Parent Educators must renew annually with PAT by completing a required number of annual professional development hours and paying annual renewal fees. Certified agencies maintain their status as a PAT affiliate by submitting their annual Affiliate Performance Report (APR) and by remaining in compliance with the Essential Guidelines. A comprehensive Affiliate Assessment must be completed on a four year cycle to validate compliance.

Once agencies are certified by HEALTH to provide one or both of these programs, HEALTH will facilitate the Application for Affiliation with HFA and the Readiness Reflection and Affiliation Plan with PAT. Agencies certified by HEALTH must submit applications to the respective models within 30 days of award from HEALTH.

2.5 Certification

Certification as a MIECHV provider is required for HEALTH to reimburse for provision of these services

Should additional funding become available through sources such as a Medicaid, a MIECHV provider must be enrolled with Medicaid as a provider of these services. If you have any questions about the Medicaid enrollment form or enrollment process, please call 1-800-964-6211.

Should additional funding become available to expand the scope of this project and models implemented through MIECHV, providers would be expected to expand their programs to:

1. Collaborate with HEALTH to outreach and enroll specific target population(s) in additional designated community(s).
2. Work with HEALTH and the evidence based models to provide services to additional pregnant women and families and continue to meet the requirements of the models.

2.5.1 Possible Outcomes of Certification Review Process

Certification applications will be reviewed and scored based on the degree to which an applicant demonstrates a quality program that complies with the requirements set forth in these Certification Standards.

Three outcomes are possible as a result of the application review process. These are:

- ☐ Certification—no conditions
- ☐ Certification—with conditions
- ☐ No certification

As a result of the review, applications may be deemed in compliance with all requirements and be offered “Certification--no conditions”. Alternatively, an applicant may describe a program that meets most of the Certification Standards, but for an identified reason does not fully comply with the certification requirements at the time of application submission. In such case, the applicant may be offered “Certification--with conditions”; application deficiencies will be identified by the State. The applicant will be required to address these deficiencies, within a timeframe determined by HEALTH, by submitting an amended proposal with specific dates for addressing deficient areas of compliance. This plan must be accepted and approved by HEALTH.

HEALTH reserves the right to accept or reject any or all applicants. HEALTH reserves the right to award in whole or in part, and to act in the best interest of the State of Rhode Island. Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further. Proposals that do not include all of the requirements will not be considered for the specific components they are applying to provide.

2.6 Continued Compliance with Certification Standards

Certified MIECHV providers shall comply with these Certification Standards and the standards of the evidence based models provided throughout the period of certification. Failure of HEALTH or the evidence based models to insist on strict compliance with all Certification Standards and performance standards shall not constitute a waiver of any of the provisions of these Certification Standards and shall not limit HEALTH's right to insist on such compliance. HEALTH will monitor and evaluate providers for compliance with Rhode Island laws, as well as these Standards. For purposes of quality assurance reviews, certified and provisionally certified providers will provide access to appropriate personnel and written records requested by HEALTH and/or its agents at reasonable times. All supervisors and direct services staff will be required to maintain a professional development plan, to be shared with HEALTH, including any proof of certifications, trainings and course completions.

Once agencies are certified, HEALTH and the national program models will monitor the performance of certified providers. Certified providers are required to notify HEALTH and the individual program models, if appropriate, of any material changes in their organization's circumstances or in program operations within 30 days of the changes. On the basis of ongoing monitoring, HEALTH staff and the individual models may identify deficiencies in performance and/or compliance with certification requirements.

At least once every year for each of the three years from the original date of certification, HEALTH will complete an on-site review of currently certified providers to assure continued compliance with Certification Standards and compliance with standards of practice, data requirements, the Continuous Quality Improvement plan and evaluation activities. The national offices of HFA and PAT will work with sites providing services to ensure model fidelity. Throughout the duration of the Certification Standards, agencies must maintain compliance with national model requirements for of the programs they provide.

HEALTH reserves the right to apply a range of sanctions to providers that fall out of compliance for any reason. These may include:

- 1) Change of certification status to certification with conditions.
- 2) Referral of eligible pregnant women, children and their families to another similar service, including First Connections.
- 3) Referral to appropriate legal authorities.

2.6.1 Conditional Certification

As a result of its review activities, HEALTH and national program models may identify deficiencies wherein a provider is not in satisfactory compliance with the certification, performance standards or model fidelity standards. In such an instance, HEALTH will notify the provider in writing of such deficiencies, work with the agency to provide a corrective action plan acceptable to HEALTH and set forth a period of time within which the provider must come into compliance. The corrective action plan must include specific steps to be taken to come into compliance and defined dates for achievement of those steps. Under no circumstances shall the period for correction exceed thirty (30) days from the date of notification of deficiency.

In the absence of a plan acceptable to HEALTH and/ or the national HFA and PAT models, or in the event of failure to meet the timelines in the corrective action plan, HEALTH retains the right to modify the certification status of the provider to conditional. Conditional Certification will remain in effect until HEALTH determines that there is satisfactory resolution of deficiencies. The duration of Conditional

Certification status shall not exceed two months, at which point continued non-compliance with requirements should result in revocation of certification

2.7 HEALTH Responsibilities

HEALTH has the responsibility to inform appropriate State agencies of any instances of fraud, suspected fraud or misuse of funds, including Medicaid funds, and professional misconduct.

The MIECHV provider is obligated to comply with all applicable state and federal rules and regulations. Certified providers agree to comply with provider and specific model requirements. HEALTH reserves the right to amend MIECHV Program requirements periodically, with reasonable notice to certified providers.

3. Target Populations, Model Allocation by Community, Referrals and Required Services

3.1 Priorities for Home Visiting through the MIECHV Program

Through the federal MIECHV Program, specific populations were highlighted as potential priority populations for home visiting. A statewide [Needs Assessment](#) demonstrated that pregnant women and families with young children residing in the six core cities in Rhode Island (Central Falls, Newport, Pawtucket, Providence, West Warwick and Woonsocket) were at highest risk for poor outcomes. In Rhode Island, women under the age of 21, with low education and who have low incomes¹ will be prioritized to receive services. In addition, families with those risk factors who are also in the Armed Forces or have prior involvement with the child welfare system will also be given high priority. MIECHV providers may provide services to pregnant women and families with young children outside of the priority populations for home visiting with prior permission from the program coordinator at HEALTH. Any changes to the overall priorities for MIECHV will be communicated to the providers directly by HEALTH.

3.2 Estimates of home visiting slots per model by community

The funding distributed through this opportunity is for the communities of Providence and West Warwick, and the models that will be funded are PAT and/or HFA. A total of \$3,195,000 annually will be provided for agencies to implement HFA in Providence and West Warwick and PAT in Providence to fund currently uncovered areas. The initial contracts will be for 12 months, and subsequent years will be for 12 months.

Community Specific Eligibility Data and Allocation of HFA and PAT Slots by Community Through This Funding Opportunity (Providence & West Warwick)

| Providence | | |
|-----------------------------|----------------------------------|--|
| <u>Evidence Based Model</u> | <u>Number of Slots per Model</u> | <u>Maximum Number of Agencies funded per Model</u> |
| Parents as Teachers | 72 | 3 |
| Total in Providence | 72 | 3 |

| West Warwick | | |
|------------------------------|----------------------------------|--|
| <u>Evidence Based Model</u> | <u>Number of Slots per Model</u> | <u>Maximum Number of Agencies funded per Model</u> |
| Healthy Families America | 25 | 1 |
| Total in West Warwick | 25 | 1 |

¹ Low income is defined as on Medicaid/ RItE Care or eligible for those services; low educational attainment is defined as a high school diploma, GED, or less.

A slot is either a pregnant woman or a parent/child dyad.

HFA requires a minimum of 25 slots to become a HFA affiliate. PAT requires a minimum of 12 slots to become a PAT site.

An agency must apply to provide at least the minimum number of slots per model, however it can also apply to provide the maximum per model by community. There will be some economies of scale in providing greater numbers of slots. Agencies may also apply to provide more than one model and/ or provide the model(s) in more than one community. An agency must provide compelling justification for serving a community in which it is not located, including how it will meet the community needs and be connected with the community. HEALTH will not certify an agency to provide more slots in a community than is estimated in the above table.

Once a tentative award is made, HEALTH reserves the right to negotiate with awarded agencies to ensure that both communities where MIECHV Program services are to be provided are adequately covered.

3.4 Pregnant Women and Families Not Eligible for the MIECHV Program

Pregnant women and families in need of services but not able to enroll in the MIECHV Program (because they are not a targeted priority for services, the capacity of the program has been maximized, or the services will not meet the family's needs) must be provided a referral to First Connections and/ or appropriate services within their community within 48 hours and/or 2 business days after the referral has been received and assessed by the MIECHV provider.

3.5 Timeframe for Enrollment MIECHV Programs

Each evidence based home visiting model has a predetermined time period when pregnant women and families with young children may enroll. All MIECHV providers must enroll eligible pregnant women and families during those periods per each model's fidelity requirements.

3.6 Referrals

Certified MIECHV providers will work with HEALTH, Local Implementation Teams and other identified entities in each community to develop a referral process/system for pregnant women and families with young children. All MIECHV providers will coordinate with First Connections providers, Local Implementation Teams, Community Health Workers, the Home Visiting Network, and other identified entities in each community on referrals for pregnant women and families with young children.

3.6.1 Capacity to accept referrals

The certified MIECHV provider must have the technological and staffing capacity to accept referrals from multiple referral sources. The agency must have a dedicated fax for the program to accept referrals. The agency must also provide a phone number and clear point of contact to community referral sources and to the public. An agency must have the ability to accept phone referrals Monday through Friday during standard business hours. An agency may choose to accept referrals and provide services on the weekends and after hours. This must be communicated to HEALTH and the specific program, if necessary. Any changes to the accepted schedule must be communicated to HEALTH 30 days in advance, in writing. Should the capacity to make electronic referrals for pregnant women and older infants be developed, the certified agency will be responsible for obtaining and maintaining the technological capabilities and procedural safeguards to accept referrals electronically. The agency must be able to download these referrals daily from KIDSNET.

3.6.2 Response to referrals

All pregnant women and families with young children referred to HFA and PAT are to be contacted within 48 hours and/ or two business days after the MIECHV provider has received the referral. As a response to referral for HFA, the model requires that the Kempe Family Stress Checklist assessment tool be completed either prenatally or within two weeks of a child's birth to assess the appropriate services

and programs for the family; the first home visit must occur prenatally or within three months of the child's birth.

3.6.3 Referral Sources

Referrals to specific programs within the MIECHV Program will come from different locations and sources within each community. These include, but are not limited to, health care providers, including OB-GYN providers, family health and pediatric providers, health centers and hospitals, WIC agencies, the Department of Children, Youth and Families, and health insurance plans. Within two months of award, certified MIECHV providers will be responsible for having a designated point of contact with each referral source. Selected agencies must work with Local Implementation Teams to develop and document these contacts and provide proof of such to HEALTH.

4. Health Equity and Culturally and Linguistically Appropriate Services

4.1 Commitment to Health Equity

Health Equity is defined as providing all people with fair opportunities to attain their full health potential to the extent possible (Braveman, 2006). Health inequities are a subset of health inequalities or disparities involving circumstances that may be controlled by a policy, system, or institution so that the disparity is avoidable. Health equity concerns itself with those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – and thus inherently unjust and unfair. WHO (World Health Organization) defines a healthy city as "one that is continually creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential."

One of the measures of the health of a community is its children's social and environmental determinants of health. The well being of children is an important part of human and community development. HEALTH is specifically interested in the developmental milestones of children from birth to age three. This is the period for which a child's physical, cognitive, social and emotional development is formed. The intentional requirement to address the social determinants of health of children birth through age 3 is the realization of a long-term vision that all children will have the opportunity for healthy social and emotional development as a foundation for their success in school and in later life. HEALTH is looking to explore maximizing early childhood development, supporting a system of health promotion, prevention and care within the context of the family and the larger community.

In Rhode Island, the Division of Community, Family Health & Equity at the Rhode Island Department of Health (DCFHE) is committed to providing quality services throughout an individual's life course. The Life Course Perspective suggests that a complex interplay of biological, behavioral, psychological and social protective and risk factors contributes to health outcomes across the span of a person's life. Disparities in health outcomes result from differences in protective and risk factors between groups over the course of their lives. As a result, the health and socioeconomic status of one generation directly affects the health status of the next one. The Life Course Perspective integrates a focus on critical periods and early life events with an emphasis on the cumulative impacts of negative experiences over time (Contra Costa Health Services, April 2005). All MIECHV providers must provide services through the lens of health equity and maintain a commitment to health equity by providing quality services to promote positive health and developmental outcomes for the families and children served by the program.

4.2 Cultural Competence

Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes. Competence in cross-cultural functioning means learning new patterns of behavior and effectively applying them in appropriate settings. HEALTH is committed to ensuring that all supervisors and direct service staff providing the

MIECHV services have cultural competency associated with the community(s) where they are providing services. Cultural competency is one of the mandatory core competencies required of staff.

4.3 Culturally and Linguistically Appropriate Services

The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) issued by the Federal Office of Minority Health in 2004 outlines mandates and guidelines for the provision of language access services, culturally competent care and organizational supports for cultural competence in health care settings.

All agencies that contract with HEALTH for the MIECHV Program must perform the following tasks and provide documentation of such tasks upon request of a HEALTH employee:

1. The supports and services provided by a MIECHV provider shall demonstrate a commitment to linguistic and cultural competence that ensures access and meaningful participation for all eligible families. Such commitment includes acceptance and respect for cultural values, beliefs and practices of the community(s) where services are provided, as well as the ability to apply understanding of the relationships of language and culture to the delivery of supports and services through the home visiting program models and curriculums. MIECHV providers must have an education, training and staff development plan for assuring culturally and linguistically appropriate service delivery.
2. All MIECHV providers must have a comprehensive cultural competency plan that addresses the following: 1) the identification and assessment of the cultural needs of potential and active clients where services are provided, 2) sufficient policies and procedures to reflect the agency's value and practice expectations, 3) a method of service assessment and monitoring that works in conjunction with the model fidelity requirements for Healthy Families America and Parents as Teachers, 4) ongoing training to assure that staff are aware of and able to effectively able to implement policies. All certified agencies are required to submit a cultural competency plan within 90 days of award.
3. MIECHV providers shall have a plan to recruit, retain and promote a diverse staff and leadership team, including Board members, representative of the demographic characteristics of the populations served.
4. MIECHV providers shall assure equal access for people with diverse cultural backgrounds and/or limited English proficiency, as outlined by the Department of Justice, *Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*. MIECHV Program providers must provide language assistance services (i.e. interpretation and translation) and interpreters for the deaf and hard of hearing at no cost to the client. Applicants should submit their agency's written policies and procedures relevant to working with people of diverse cultural background and/or limited English proficiency that meet the requirements of items i – v below and their plan for securing an interpreting service, if their agency does not already have one in place.
 - i. Providers must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/ consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
 - ii. Providers must provide to patients/ consumers in their preferred language, both verbal offers and written notices, informing them of their right to receive language assistance services.
 - iii. Providers must assure the competence of language assistance provided to limited English proficient patients/ consumers by interpreters and bilingual staff. Family and friends should not

be used to provider interpretation services (except on request by the patient/ consumer). Children should never be used as interpreters.

- iv. Providers must make easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/ or groups represented in the service area. HEALTH and the home visiting models will work with providers to develop and distribute these materials.
- v. Certified providers are required to have a Memorandum of Agreement or contract with a minimum of one interpreting and translating service.

MIECHV providers must indicate how culturally and linguistically appropriate services will be delivered to racial and ethnic minority populations. Per federal standards released in November 2011, OMB Directive 15 identifies racial and ethnic minority populations: Mexican, Mexican American, Chicano/a, Puerto Rican, Cuban, Another Hispanic, Latino/a, or Spanish Origin, Not Hispanic, Latino/a, or Spanish Origin (Ethnicity) and White, Black or African American, American Indian or Alaska Native, Asian-Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian, Native Hawaiian or Other Pacific Islander- Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander. HEALTH will support agencies in providing cultural competency training through the Home Visiting Network and other identified opportunities to achieve the level of competency required by CLAS Standards through Technical Assistance and training. HFA and PAT may also require cultural competency trainings and a demonstration of their model specific commitment to providing culturally appropriate services through model delivery.

5. MIECHV Program Personnel

5.1 General Qualifications

With respect to ensuring staff competency, the MIECHV provider shall have policies and procedures in place for all employees consistent with HEALTH certification. This requires that:

Licensed and certified professionals conform to continuing education requirements specified by their respective credentialing bodies

- 1) Educational backgrounds and experience align with position qualifications
- 2) Appropriate competency training, agency orientation sessions and specific model and curriculum trainings are completed.
- 3) Recent employment experience is relevant for target population
- 4) Employment background checks, Background Criminal Investigations (BCIs) and CANTS are performed for all potential employees.

5.2 Specific Staff Qualifications by Evidence Based Program Model

All qualified professionals providing MIECHV services, whether employed on a full-time or part-time basis for which certificates, licenses, or registrations are required by state law and regulations, must hold current certificates, licenses, or registrations. Only those professionals that hold such certificates, licenses, or registrations and meet the highest requirements in the State applicable to a specific profession or discipline may be considered qualified professionals. This documentation may be checked during site review by HEALTH.

5.3 Supervision

Certified MIECHV providers must demonstrate the capacity to provide and document the specific supervision requirements of the evidence based home visiting models they are providing. All program supervisors must use reflective supervision practices. Supervisors and program managers (if applicable) must attend all required model and curriculum specific trainings. Supervisors and/ or program managers are required to attend monthly Local Implementation Team meetings, monthly Maternal and Child Health meetings and participate in the Home Visiting Network.

5.4 Additional Staffing Structure

The work of all certified MIECHV staff must be systematically organized with clear roles, reporting relationships, and supervision within each evidence based home visiting model. If the agency is a multi-service organization, an applicant must illustrate how MIECHV services and the specific models fit into the organization as a whole. HEALTH will work with certified providers to provide job descriptions specific to each position within each model (see Section 6.3 Professional Development).

Job descriptions must address the following areas:

1. Functional tasks and responsibilities
2. Required skills, training, and experience
3. Licensure or certification qualifications, when applicable
4. Reporting relationships
5. Percentage of time dedicated to program

It is the responsibility of a certified MIECHV provider to conform to certification requirements regarding staff credentials, training, personnel management and guidelines. Certified MIECHV providers must demonstrate acceptable staffing ratios per each model's fidelity requirements. Additionally, documentation of relevant education, qualifications and experience of staff and contracted providers must be maintained at certified provider sites for review by HEALTH and/ or the specific models.

6. Provider Orientation and Training

All certified MIECHV staff is required to participate in the mandatory training requirements for each model provided, including curriculum training, and any trainings required by HEALTH.

6.1 Home Visiting Network

All staff providing home visiting services to pregnant women or families with young children, regardless of their program affiliation, will be invited to participate in the Home Visiting Network. All direct service staff and supervisors providing MIECHV home visiting services will be required to participate in the Home Visiting Network. HEALTH and its partners will develop core competencies for home visitors, define a system of standards to be achieved by the home visiting workforce and support multi-disciplinary training for home visitors through the Home Visiting Network.

6.2 Core Competencies for all Home Visitors

All home visitors in programs supported through HEALTH will be required to have core competencies in subject areas identified by HEALTH and its partners. Some subject areas are covered in individual model trainings and will be supported by HEALTH and the agencies providing services. All home visitors providing MIECHV services must receive training and be competent in the following subject areas:

- Maternal prenatal and postpartum care
- Infant care
- Healthy homes
- Child development
- Breastfeeding/Nutrition
- HIPAA, ethics and confidentiality
- Training in behavioral health, inclusive of mental health and substance abuse, domestic abuse and interpersonal violence, with comprehensive training in the current screening tools for depression and substance abuse
- Referrals and linkages to programs at statewide and community levels that will support families in reaching the goals they have set for themselves and mitigating their risk for poor outcomes
- Identification of risk factors for child abuse and neglect, mandatory reporting laws for children, elders and those with disabilities
- Motivational interviewing
- Using a Life Course approach and health equity

- Providing culturally appropriate services that reflect the demographics of the State and the specific communities where services are provided
- Culturally and Linguistically Appropriate Services (CLAS) standards

If specific models do not provide training within their requirements, HEALTH will ensure that home visitors can access training. Should the need for additional core competencies arise, home visitors will be required to become competent in the identified subject areas.

6.3 Professional Development

All MIECHV service providers must complete professional development plans and/ or number of hours of training required by the individual models. Home visitors and supervisors will be required to maintain a detailed professional development plan, including dates of completed training and professional development hours, and provide copies of the plans to HEALTH as requested.

7. MIECHV Program Requirements

HFA and PAT are distinct evidence based home visiting models, each model has its own prescribed method of providing services and models must be implemented with fidelity.

7.1 Model fidelity

Model fidelity in evidence based home visiting refers to the prescribed replication of services. HFA and PAT and related curricula are to be implemented with strict conformity to the standards established by each model and curriculum. MIECHV providers will be required to participate in regular fidelity team meetings with HEALTH staff to ensure that each model being implemented by an agency is implemented with fidelity. Certified MIECHV providers must implement the program per the model fidelity, including required staffing and structure.

7.2 MIECHV Program Required Assessment Tools

Through the MIECHV Program, certified providers across all models will be required to use specific standardized tools to assess and provide data for program evaluation, Continuous Quality Improvement, health-related data, and mandated benchmarks. All certified MIECHV providers are required to use these tools, in addition to other model specific tools that may be required at specific time periods as mandated by HEALTH and/ or the specific models.

Required tools include:

- Ages and Stages Questionnaire (ASQ-3)
- Ages and Stages Questionnaire: Social Emotional (ASQ:SE)
- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Abuse Screening Test (DAST-10)
- Patient Health Questionnaire-9 (PHQ-9)
- Home Observation for Measurement of the Environment Inventory (HOME)

Additional details on the above listed tools can be found in Appendix 4. The individual evidence based models may use additional required tools that are not mentioned above. For example, PAT requires the use of Life Skills Progression.

7.3 Required Components of the MIECHV Program

Through the MIECHV Program, an infrastructure for maternal and child home visiting programs has been developed to ensure that there is a comprehensive and coordinated system of home visiting services along a continuum of need for all families.

7.3.1 Local Implementation Teams

Local Implementation Teams will be developed each community where the MIECHV Program is implemented. Local Implementation Teams will collaborate at the community level, coordinate referrals, provide feedback about implementation in the community, and work with the Home Visiting Leadership

Council to align programs and policies. Local Implementation Teams will include community organizations providing services to pregnant women and families with young children, home visiting providers, members of the community, and Community Health Workers. All Certified MIECHV Program Managers and Supervisors are required to attend Local Implementation Team meetings.

7.3.2 Model Fidelity Teams

Model Fidelity Teams will be in place for each of the models implemented in Rhode Island through the MIECHV Program. These teams are in place to ensure that each model is implemented to fidelity and meets specific model and state objectives. All certified MIECHV Program Managers and Supervisors are required to attend Model Fidelity meetings. Home Visitors will be required to attend meetings, when appropriate.

7.3.3 MIECHV Program Manager Meetings

These meetings are monthly administrative meetings and serve as regular, coordinated check-ins between HEALTH staff and program managers. Policies and procedures and continuous quality improvement strategies are reviewed, in addition to MIECHV Program data. All certified MIECHV Program Managers and Supervisors are required to attend MIECHV Program Managers meetings. Home Visitors will be required to attend meetings, as needed.

7.3.4 Home Visiting Network

All home visiting staff, regardless of program affiliation, will be invited and encouraged to participate in the Home Visiting Network. All home visitors providing services through the MIECHV Program are required to participate. All Home Visitors and Supervisors will be offered multi-disciplinary training developed in collaboration with the Home Visiting Leadership Council, RI's Early Learning Council, RI's Infant Mental Health Association, model developers and others. These trainings will be offered quarterly, provided through the Home Visiting Network and supported by HEALTH.

7.4 Community Collaboration

Though these certification standards, the MIECHV Program seeks to provide services to eligible pregnant women and families with young children in the designated communities of Providence and West Warwick. MIECHV recognizes that enhanced service coordination in surrounding communities in each community's region, as well as program linkages, are critical to meeting the needs of participants. All certified MIECHV Program providers must demonstrate the capacity to serve both the specific community(s) and form partnerships and opportunities for collaboration in the surrounding region. All certified providers will be required to have Memoranda of Understanding with specific service provider types in their communities and/ or region with clear points of contact and provide proof of such to HEALTH.

Specific provider types include, but are not limited to:

- Primary Health Care Providers
- Early Intervention providers
- Domestic Violence Service providers
- Alcohol and Illicit Drug Treatment providers
- Tobacco Cessation providers
- Mental Health Service providers
- Education providers
- Health Insurance Plans
- Local Department of Human Services office
- Local WIC sites
- Local Housing Authorities
- Other home visiting programs, including First Connections

Applications must provide evidence of existing Memoranda of Understanding. Certified providers will be expected to increase the number of Memoranda of Understanding by 20% per years of providing services. This is a mandated benchmark.

Certified MIECHV providers are responsible for developing and maintaining knowledge of community supports and assisting families in accessing them. Community coordination with other local agencies will be expected and will be favorably factored into the scoring process. Applicants must describe current community partnerships and collaborations and how they currently integrate their services with other agencies that serve children and families.

7.5 Outreach and Engagement

Outreach should be local, systematic, family centered and community based and should utilize a HEALTH-funded Community Health Worker in each community, if available. Each community should tailor its outreach approach to meet community needs. Outreach and engagement includes communication with the general population, primary referral sources, pregnant women, and families for the purpose of raising their understanding of the community supports and services available to all eligible families. The goal of outreach and engagement is to increase awareness of the Rhode Island's home visiting programs, increase community engagement in Rhode Island's home visiting programs, and develop referral pathways for children and families that would potentially benefit from evidence based home visiting programs.

7.5.1 Outreach Plan

The agencies awarded contracts for MIECHV services will be expected to submit a detailed outreach plan, within 60 days of notification of certification. All activities need to be developed and coordinated within the parameters of the evidence based model's service delivery plan. The plan should include:

- A protocol for contacting a family for the first time, including the type of professional who will make the initial contact, consistent with each evidence based model's standards and fidelity requirements.
- How the agency plans to meet the needs of families from different cultural backgrounds.
- How the certified provider plans to locate and meet the needs of pregnant women and families with multiple risk factors (for example, how they would contact a family without a telephone, or one that speaks a language other than English or Spanish).
- How the agency will coordinate services with other service providers in communities. Agencies must provide documentation that they have participated in local community events. Agencies will be expected to participate with the FCCP at the level of the local advisory board.
- How the agency will provide information in appropriate languages regarding the specific evidence based models and/ or MIECHV Programs. See Section 11, Marketing Promotions and Forms for additional details.

8. Data Systems and Entering Data

All certified MIECHV providers will be required to input program and visit data into an electronic data system(s) approved by HEALTH, within specified timeframes. Providers must demonstrate that they have the current technology and capability to support the required data entry and describe their infrastructure and information technology support within their organization.

8.1 Efforts to Outcomes

Certified MIECHV providers will be expected to record data collected at every home visit and at specific times per HEALTH and the evidence based models. Agencies must demonstrate the capacity to enter this data directly into the designated MIECHV Program database module of Efforts to Outcomes in the timeframe prescribed by each home visiting model. Documentation of home visits must be entered within 24 to 48 hours or two business days after the home visit.

8.2 KIDSNET

Agencies will be expected to have the capacity to use KIDSNET to track outcomes not captured in Efforts To Outcomes.

KIDSNET is an integrated child health data system at HEALTH. KIDSNET creates a child profile allowing HEALTH programs and primary care providers to obtain information about preventive public health services received by the family. HEALTH will train staff at the certified agencies to use KIDSNET, but the agency must demonstrate capacity to enter data into the KIDSNET system in a timely manner, to share and transfer information electronically. As HEALTH moves toward electronic data exchange, certified MIECHV Program providers will be expected to participate in this and show capacity to enhance their technology to meet the needs of the program.

The MIECHV Program uses data to inform the performance, stability, and quality of services provided to pregnant women and families with young children. Agencies applying to provide services must demonstrate the capacity to:

- 1) Utilize the most current version of the data system as prescribed by HEALTH.
- 2) Maintain a written plan for information management which includes: client record-keeping policies and procedures; confidentiality policies and procedures; and record security policies and procedures. The plan provides for the timely and accurate collection of data and sets forth a reporting schedule.
- 3) Ensure that its information management systems are protected from unauthorized outside access and meet all applicable HIPAA regulatory requirements.
- 4) Information management processes are planned and designed to meet the organization's internal and external reporting and tracking needs, and are appropriate to its size and complexity. Mechanisms exist to share and disseminate information both internally and externally.
- 5) The organization has written policies and procedures regarding confidentiality, security, and integrity of information, and has mechanisms to safeguard records and information against loss, destruction and unauthorized access or disclosure. The agency should demonstrate:
 - i. It maintains signed releases for sharing of information.
 - ii. It maintains Memorandum of Agreement where necessary.
 - iii. It has policies and procedures in place to safeguard administrative records, clinical records, and electronic records.
 - iv. Electronic records are backed up, transmitted data is encrypted and secure, and access is password protected.

HEALTH may request additional reports, documentation, and site visits as necessary to monitor compliance with these certification standards and services provided by the certified MIECHV provider.

9. Performance Measures

The MIECHV Program includes a detailed Continuous Quality Improvement (CQI) Plan, strong performance measures and a comprehensive evaluation. In addition, each evidence based model has distinct performance measures that must be achieved by each implementing agency.

9.1 Continuous Quality Improvement Plan

Rhode Island will use CQI methods in the MIECHV Program. Incorporating CQI into the home visiting infrastructure will result in more effective program implementation and improve outcomes. Through the collection and regular use of data, Rhode Island's home visiting programs can identify and address impediments to effective performance, as well as document changes and improvements.

Applicants must submit a proposed, agency specific, CQI Plan with their application. All certified MIECHV providers will also be required to participate in HEALTH's CQI plan. Successful applicants must demonstrate their ability and their experience to affect change using CQI in their programs and services. Applicants should describe their experience with monitoring performance using program data to

assess and enhance program quality and management and how they support staff to use program data to improve practice results. Through training and monitoring, HEALTH will ensure data safety, monitor the privacy of data and utilize administrative procedures that do not place individuals at risk of harm and comply with applicable regulations related to the Institutional Review Board (IRB), HIPPA and FERPA. Training related to data privacy, using data appropriately, HIPPA and FERPA will be required as a core competency for all MIECHV Program staff.

9.2 Mandated benchmarks

In the MIECHV Program 38 specific constructs among six distinct benchmark areas have been identified for states to develop related process and outcome measures that they will use to demonstrate progress toward improving outcomes. HEALTH and its partners have developed Rhode Island specific constructs within each of the six benchmark areas, these are:

- Maternal and Newborn Health
- Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
- School Readiness and Achievement
- Domestic Violence
- Family Economic Self-Sufficiency
- Coordination and Referrals for Other Community Resources and Supports

The 38 construct measures proposed are developmentally appropriate for the corresponding constructs and appropriate for use with the populations served by the MIECHV Program. To measure progress towards intended outcomes, information to assess every construct will be collected at time of enrollment, during enrollment, at one year post enrollment and/ or at time of discharge from the evidence based program, as well as other specific time points as designated by HEALTH. Benchmark related data will be reported using specific forms required by HEALTH and/ or the evidence based models. HEALTH's mandated MIECHV benchmarks are included in Appendix 5.

In addition to the data collected for the mandated benchmarks, certified providers must collect individual-level demographic and service utilization data on the participants in their program to analyze and understand progress made by children and families. Certified MIECHV providers are required to use the current standards for federal reporting on language and disability status and the data collection standards for race, ethnicity, sex, language, and disability status. This data includes, but is not limited to:

- Family's participation rate in the home visiting model
- Demographic information for participant children, pregnant women, expectant fathers, parents, or primary caregivers receiving home visiting services, including child's age and gender, age of all at each data collection point and racial and ethnic background of all participants in the family
- Participant child's exposure to language other than English
- Family socioeconomic indicators

All data will be entered and stored in the designated data system(s) for the program. Agencies must demonstrate the capacity to enter data directly into the designated MIECHV Program database module in the timeframe prescribed by each home visiting model.

9.3 Model Specific Performance Measures

HFA and PAT have specific model measures that must be adhered to by the agencies implementing the models. All certified MIECHV providers will be required to meet the specific performance measurement requirements of the model(s) they are implementing per model fidelity requirements.

10. Qualified Entity

A certified MIECHV provider must be able to demonstrate capacity regarding organizational and administrative structure to support the program. These requirements are in addition to the standards and requirements of HFA and PAT.

10.1 Administration

Specific standards regarding administration are as follows:

- 1) The Executive Officer, under supervision of the governing body, is responsible for financial management, achieving program outcomes, meeting client needs, and implementing the governing body's strategic goals.
- 2) A current organizational chart, which clearly defines lines of authority within the organization, is maintained and provided as part of the certification application. These charts are also necessary for the specific evidence based models agencies are applying to implement.
- 3) The management of the organization is involved in the planning process for performance improvement and the evaluation and is involved in planning for priorities and setting goals and objectives for the written Quality Assurance/Performance Improvement and Continuous Quality Improvement plans.

10.2 Financial Systems

The organization must have strong fiscal management that makes it possible to provide the highest level of service to families with young children. The organization must be able to obtain relevant data, process and report on it in meaningful ways, and analyze and draw meaningful conclusions from it. Managers must use financial data to design budgets that match the constraints of the organization's resources, and provide ongoing information to aid the governing body in managing and improving services. Therefore, the financial managers must have the ability to integrate data from all of the client and financial accounting systems (e.g., general ledger, Medicaid and commercial insurance billing and appointment scheduling). Data must also be utilized to make projections for planning and budgeting purposes.

10.2.1 Reporting and Billing

HEALTH must meet its obligation to monitor and assure that the requirements of the contracts to be awarded under these standards are met. The following reporting and billing criteria have been established:

- Agency will bill monthly for services rendered (bills must be received by the 10th day of the month for services provided in the prior month).
- Agency must comply with federal and state standards to safeguard the use of funds. Documentation and records of all income and expenditures must be maintained as required.
- Agency will document all activities related to this initiative and make them available to HEALTH when requested, for purposes of monitoring or quality assurance
- Should funding become available from Medicaid, direct service agencies must demonstrate ability to bill Medicaid for services and maximize Medicaid collection and reconcile Medicaid billings.
- Provide documentation of general liability insurance covering the services provided annually and/or upon request.

10.3 Budgets

10.3.1 Budgets for each evidence based model

The applicant is required to submit a complete 12-month program budget with a justification narrative which will cover all estimated financial needs for each evidence based model that the applicant is proposing to provide, see Appendices 2-3, for model specific budget templates. The budget should be presented in Excel format, itemized and include personnel, fringe, travel, printing/copying, office supplies, telephone/internet/fax, educational materials, equipment, postage, other costs, and indirect costs. A 10% verifiable agency match from non-federal sources is required, and agencies that can demonstrate additional funding and services will be given priority. The accompanying budget narrative should be as

detailed as possible. If the financial plan is not acceptable, HEALTH reserves the right to request a revised financial plan.

10.3.2 Definitions of costs for all budget narratives

- Personnel costs: Personnel costs must be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full time equivalency, hourly rate, annual salary, and total hourly cost. If a position needs to be filled, indicate that the position is “To Be Identified”.
- Fringe benefits: List the fringe rate and the components that comprise the fringe benefit rate, for example, health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits must be directly proportional to that portion of personnel costs that are allocated to the project.
- Travel: List travel costs according to in-state and out-of-state travel. For in-state travel, the mileage rate and number of miles per month. The budget must also reflect the travel expenses associated with participating in meetings, trainings and workshops. These must be broken out by airfare, hotel, and registration.
- Printing/Copying: List printing and copying costs associated with the project.
- Office Supplies: List the items that the project will use (i.e. paper, pens, pencils, etc.).
- Telephone/Internet/Fax: List itemized telephone/internet fax expenses.
- Educational Materials: List educational materials and supplies.
- Equipment: List equipment costs and provide justification for the need for the equipment to carry out project goals. Equipment includes computer hardware and printers.
- Postage: List postage expenses.
- Other (Specify): Put all costs that do not fit into any other category into this category (including HFA/GGK and/or PAT/LSP model specific training and education and professional development costs and provide an explanation of each cost in this category. In some cases, rent, utilities, and insurance fall under this category if they are not included in an approved indirect cost rate. Applicants may include the cost of access accommodations as part of their project’s budget, including sign interpreters, plain language and health literate print materials in alternate formats and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings. Fixed HFA and/or PAT model fees must be included in this category. Other costs that may be included in this category are professional fees (i.e. audit, legal, data processing, etc.), advertising/recruitment, equipment rental, client transportation costs, maintenance costs, etc. if they are not included in an approved indirect cost rate. The methodology for how the agency arrived at each cost must be included.
- Indirect costs: Indirect costs are those costs incurred for common or joint objectives which can not be readily identified but are necessary to the operations or the organization (e.g. the cost of operating and maintaining facilities, depreciation, and administrative salaries). The applicant must provide supporting documentation on the categories (and their percentages) included in the indirect cost rate. The applicant must also provide a copy of a current federally approved indirect cost agreement if available.

10.4 Human Resources and Staffing

The organization must demonstrate that it provides clear information to staff about job requirements and performance expectations, and supports continuing education, relevant to the job requirements of the individual. It must also demonstrate that it assists staff in maintaining and documenting required professional development.

Specific standards regarding Human Resources and Staffing are as follows, and must be explained in the application to become certified:

- 1) The organization’s personnel practices must contribute to the effective performance of staff by maintaining sufficient staffing ratios through direct hiring of qualified individuals and agencies that are culturally and linguistically competent to perform clearly defined jobs and address MIECHV

Program needs. The organization's personnel practices must be maintained to meet the specific staffing requirements, including but not limited to staff to supervisor ratios and caseload limits per the specific evidence based model(s) provided.

- 2) Personnel records are kept that contain a checklist to track appropriate training, credentialing and other activities. A copy of all required current staff licenses and certifications must be kept on file. A professional development plan must also be kept on file for each staff member. HEALTH is permitted to view these files upon request.
- 3) Certified MIECHV providers must perform annual written performance appraisals of staff based on input from families and supervisors, as appropriate. These must be available in the personnel files for review by HEALTH upon request. The specific evidence based model(s) being provided may have additional requests and/or requirements that certified agencies must adhere to.
- 4) Policies and procedures contain staff requirements for cultural competency that are reflected in the job descriptions.
- 5) Staff is hired with skills, credentials, education and experience that match the requirements set forth in both the appropriate job description and in the policies and procedures per each specific evidence based model(s) provided by the agency.
- 6) Each staff person's personnel file contains a job title and description reflecting approved education, experience and other requirements, caseload expectations, supervisory and reporting relationships, and annual continuing education and training requirements. All job descriptions include standards of expected performance and personnel development plans. Each direct service staff person's personnel file must contain documented answers to specific interview questions provided by the model(s).
- 7) The organization provides a clear supervisory structure that includes delineated responsibilities and caseloads as appropriate per the requirements of each the specific evidence based model(s) provided by the certified agency. The roles of staff are defined with a clear scope of practice for each. Supervisors receive specialized training and coaching from each evidence based model to develop their capacities to function as experts in their clinical and/or technical fields. The organization holds supervisors accountable for communicating organizational goals, as well as for clinical and technical supervision. This includes:
 - a) Protocols for communication and coordination with all interested parties.
 - b) Clear procedures for addressing unmet education or licensure requirements will be stated. Credentialing records will be maintained annually to document compliance. All staff is required to maintain professional development plans.
- 8) Credentials of qualified personnel are in accordance with Rhode Island's licensing and shall be contained in the job descriptions. An individual hired into a position has his or her credentials verified through primary source verification, as appropriate, and records maintained in the staff's personnel file.
- 9) Staff is required to participate in orientation and training activities on an ongoing basis, as specified by the provider agency and individual job descriptions.
- 10) Staff is required to undergo and pass a Criminal Background Check as a condition of their hire and before providing any services. Staff already employed by an agency that has not already had a Criminal Background Check must complete one. Criminal Background Check documentation for all staff must be kept in the personnel records.

10.5 Health and Safety, Risk Management

The certified MIECHV provider must support an environment that promotes optimal safety and reduces unnecessary risk for pregnant women, families with young children, family members and staff. The service delivery models of the MIECHV Program call for specific policies and procedures to assure that services are provided in a safe and effective manner for both the family and the staff.

Standards regarding Health, Safety, and Risk Management are as follows and must be explained in the application to become certified:

- 1) The organization's policies and procedures designate managers who monitor implementation of Health and Safety policies and report to the Quality Assurance Performance Improvement program committee.
- 2) The organization has protocols for identification and monitoring of safety risks, family crises, medical emergencies and difficult situations.
- 3) Health and safety policies and procedures are clearly communicated to agency staff, visitors, and infants and toddlers and their families.
- 4) Programs will have an effective incident review process.
- 5) OSHA guidelines.
- 6) All Federal and State mandates.
- 7) The specific evidence based models may have complementary Health, Safety and Risk Management policies that must be followed.

11. Marketing, Promotion, and Forms

Any information disseminated about home visiting reflects on HEALTH and must be approved by HEALTH prior to dissemination, the MIECHV Program and the specific models. Public health messages produced should communicate the MIECHV Program goals, values, and priorities. Within HEALTH, the Center for Public Health Communication (CPHC) provides strategic guidance and assistance in developing program communications and to help ensure that messages and tone are aligned with the HEALTH's priorities and communication guidelines.

Examples of materials that should follow these guidelines include, but are not limited to: flyers, posters, brochures, data books, invitations, banners, postcards, reports, forms, newsletters, advisories, advertisements (print, radio, and TV), letters for the public requiring the Director of HEALTH's signature, public health campaign materials, press releases, legislative materials, and all materials and content posted on HEALTH's website. All communications bearing HEALTH's logo that will be disseminated via outside partners or networks, including certified MIECHV Program providers, are also included in these policies and procedures. Any materials with HEALTH's logo must be approved by HEALTH before printing. The source of funding should be listed on materials.

11.1 Agency website content, brochures and promotional materials

All certified MIECHV providers are to maintain information about the MIECHV Program and the specific model(s) provided by the agency on the agency's website. HEALTH will provide all related content to agencies to post on their website.

11.2 Translating Materials

Certified MIECHV Program providers should work with HEALTH and the CPHC to coordinate all translations of materials. A translation coordinator within CPHC will act as the liaison between the MIECHV Program and translators/reviewers.

11.3 Evidence based model requirements

HFA and PAT have policies for use of their name and logos that are to be followed by all certified MIECHV providers. PAT has logo usage guidelines. Federal copyright laws apply to all copyrighted materials. PAT has a corporate relations policy that outlines guidelines and procedures to protect the integrity of PAT and ensure the model's mission is enhanced through corporate relationships. The PAT national office does not require approval of local communications and materials development if the national PAT logo and name is not used.

11.4 Outreach Materials

Agencies may use outreach materials, such as door hangers, magnets and related items to support outreach efforts. Before outreach materials are purchased, approval from HEALTH is required.

11.5 Transportation for families

In the event that pregnant women and families participating in home visiting require transportation for services of a time sensitive nature (outside of medical emergency services), such as Newborn Bloodspot Repeat Specimen testing, certified providers must have a plan in place to provide transportation services through a cab company or similar service.

11.6 Forms used in the MIECHV Program

HEALTH and/ or the evidence based models will provide the necessary data forms for the implementation of the MIECHV Program. These forms may not be changed without the written approval of HEALTH and/ or the evidence based models.

11.6.1 HEALTH's Distribution Center

Some materials and forms that support the implementation of the MIECHV Program will be available through the Distribution Center at HEALTH. Certified providers may order materials from HEALTH's website (www.health.ri.gov).

12. Assurances

HEALTH, as the lead agency for the MIECHV Program in Rhode Island, is responsible for the implementation, fiscal reporting and overall operation of the program in Rhode Island. Awards made from these Certification Standards are conditional based on approval from the evidence based model(s). Certified MIECHV providers will be required to work with HEALTH and its designated partners on MIECHV and the specific models within the program.

**Appendix 1: Scoring Criteria Service Provider Model
Review Score Sheet**

| | |
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| Applicant: | |
| Reviewer: | |

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| Total Score: | |
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Strengths:

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Priorities for Home Visiting through the Maternal, Infant and Early Childhood Home Visiting Program (Sections 3.1 & 3.2)

| <i>Criterion</i> | <i>Points possible</i> | <i>Points given</i> |
|---|-------------------------------|----------------------------|
| Agency has clearly described which home visiting model(s) they are applying to provide, which community/ies they are applying to provide services in and has applied to provide an appropriate number of slots per model. | 5 | |
| Agency is located within the community/ies it is proposing to serve | 1 | |
| Agency has demonstrated experience working with the priorities for home visiting through the Maternal, Infant and Early Childhood Home Visiting Program. | 4 | |
| Total | 10 | |

Cultural Competence and Culturally and Linguistically Appropriate Services (Sections 4.2 & 4.3)

| <i>Criterion</i> | <i>Points possible</i> | <i>Points given</i> |
|--|-------------------------------|----------------------------|
| The policies and procedures provided by the agency adequately address Section 4.3, items i – v. | 4 | |
| Agency has a Memorandum of Understanding or contract with an interpreting and translating service or has provided a plan for securing such services. | Required | |
| Total | 4 | |

Capacity to accept referrals (Section 3.6)

| <i>Criterion</i> | <i>Points possible</i> | <i>Points given</i> |
|---|-------------------------------|----------------------------|
| Quality of evidence provided by agency regarding the capacity to accept referrals via phone and fax during standard business hours. | Required | 0 |
| Agency has demonstrated the capacity to respond to referrals within 48 hours and/ or two business days upon receipt of referral. | Required | 0 |
| Total | 0 | 0 |

Model Fidelity (Section 7.1, Appendices 2-3)

| <i>Criterion</i> | <i>Points possible</i> | <i>Points given</i> |
|--|-------------------------------|----------------------------|
| Quality of evidence provided by agency regarding their understanding and/ or experience they have with the model they are applying to provide. | 5 | |
| Agency has described how the model they are applying to provide complements agency's mission. | 1 | |
| Plan for hiring appropriate staff for each model and the community(ies) they are applying to serve. | 4 | |
| Total | 10 | |

Community Collaboration (Section 7.4)

| <i>Criterion</i> | <i>Points possible</i> | <i>Points given</i> |
|--|-------------------------------|----------------------------|
| Quality of current community partnerships and collaborations and how agencies currently integrate their services with other agencies that serve children and families. | 5 | |
| Total | 5 | |

Data Systems and Entering Data (Section 8)

| <i>Criterion</i> | <i>Points possible</i> | <i>Points given</i> |
|--|-------------------------------|----------------------------|
| Quality and depth of infrastructure and information technology support within agency to support required data system(s). | 4 | |
| Demonstrated ability of agency to enter data within specified timeframes for each model. | 2 | |
| Agency has provided an adequate, detailed written plan for information management. | 5 | |
| Agency maintains signed releases for sharing of information. | Required | 0 |

| | | |
|--|-----------|--|
| Quality of written policies and procedures regarding confidentiality, security and integrity of information. Agency has mechanisms to safeguard records and information. | 5 | |
| Total | 16 | |

Continuous Quality Improvement Plan (Section 9.1)

| Criterion | Points possible | Points given |
|---|------------------------|---------------------|
| Comprehensiveness of agency's Continuous Quality Improvement Plan related to MIECHV | 7 | |
| Total | 7 | |

Qualified Entity (Section 10)

| Criterion | Points possible | Points given |
|--|------------------------|---------------------|
| Agency has provided a description of their current organizational structure, including an organizational chart. | 2 | |
| Agency has clearly demonstrated that it has the financial ability to integrate data from all necessary client and financial accounting systems | 4 | |
| Total | 6 | |

Cost Proposal and Budget (Sections 3.2, 10.3, and Appendices 2-3)

| Criterion | Points possible | Points given |
|---|------------------------|---------------------|
| Agency submitted a W-9 form with their application. | 1 | |
| Agency has provided a budget using the template provided by HEALTH for each model they are applying to provide. | 6 | |
| Agency has submitted a detailed budget narrative explaining each line item in detail. | 6 | |
| The cost per model for each model an agency is applying to provide is close to the average cost per family for each model. | 6 | |
| Agency has committed to providing additional funding, with a minimum of a 10% verifiable agency match to support its agency's implementation of the Maternal, Infant and Early Childhood Home Visiting Program. | 6 | |
| Total | 25 | |

Human Resources, Staffing (Section 10.4)

| Criterion | Points possible | Points given |
|---|------------------------|---------------------|
| Agency has demonstrated ability to provide clear information to staff related to job performance and expectations, professional development plans and training. | 3 | |
| Agency provides a minimum of an annual written performance appraisal of staff and maintains copies of all current staff license and certifications. | 3 | |
| Agency has a clear supervisory structure. | 4 | |
| Total | 10 | |

Health and Safety, Risk Management (Section 10.5)

| Criterion | Points possible | Points given |
|---|------------------------|---------------------|
| Agency has described their written policies and procedures for health and safety policies, the incident review process, and protocols for identification and monitoring of safety risks, family crises, medical emergencies and difficult situations. | 7 | |
| Total | 7 | |

_____ **Total Score (out of 100)**

Appendix 2: Healthy Families America

Compiled from <http://homvee.acf.hhs.gov/>

Program Model Overview

Theoretical Model

HFA is a voluntary, evidence-based home visiting model that is based upon a set of critical elements that serve as the framework for program development and implementation. HFA program model components are theoretically rooted in a strength-based approach. The strength-based approach recognizes that all families have strengths and that programs should build on these strengths rather than focus on correcting weaknesses. Family Support Workers (FSWs - HFA home visitors) help families build their own abilities to manage life's challenges.

Program Model Components

HFA includes (1) screenings and assessments, and (2) home visiting services. In addition, many HFA programs offer services such as parent support groups and father involvement programs. HFA allows local sites to formulate program services and activities that correspond to the specific needs of their communities.

Target Population

HFA is designed for parents facing challenges such as single parenthood, low income, childhood history of substance abuse, mental health issues, and/or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve.

HFA requires that families be enrolled prenatally or within the first three months after a child's birth. Once enrolled, HFA programs provide services to families until the child enters kindergarten. In Rhode Island, HFA will provide services until a child turns three.

Where to Find Out More

Healthy Families America National Office
228 S. Wabash, 10th Floor
Chicago, IL 60604
Phone: (312) 663-3520
Fax: (312) 939-8962
Website: <http://www.healthyfamiliesamerica.org/home/index.shtml>

Specific Requirements of Healthy Families America in Rhode Island

HFA requires a minimum of 25 slots to become an HFA affiliate.

1. Specific Staff Qualifications

HFA uses two positions to provide direct services to families- a Family Assessment Worker (FAW) and a Family Support Worker (FSW). These positions are supported by a Supervisor and a Program Manager. Direct service staff for HFA should be hired because of their personal characteristics that support their education and experience, per the Critical Elements requirements of HFA.

HFA agencies must support at least one Supervisor, one Program Manager, one FAW and two FSWs. The number of families served by each agency will determine if one full time person may serve as both the Supervisor and the Program Manager.

Program Manager

Must be Masters level, meet the requirements of a qualified licensed professional and have a minimum of three to five years working with young children and their families as well as supervision of direct service staff. The Program Manager is responsible for the overall operation of the Healthy Families America program within the agency, as well as funding/ budgets, quality assurance activities, evaluation and assist in developing and maintaining community contacts.

Supervisor

Must be Masters level, meet the requirements of a qualified licensed professional and have a minimum of three to five years working with young children and their families as well as supervision of direct service staff. Discipline specific supervision should be provided in accordance with HEALTH practice acts. HFA Supervisors are responsible for providing weekly supervision to all direct service staff and completing some quality assurance activities and will assist in developing and maintaining community contacts.

Family Assessment Worker

Must have a minimum of an Associate Degree in Human Services, Child Developments or related field, with a minimum of two (2) years experience providing services to and/ or engaging families with infants and toddlers in services. Must have experience working with families with multiple needs

Family Support Worker

Must have a minimum of a Bachelors Degree in Human Services, Child Development, Education or related field, with a minimum of three years of public health or community development experience. Must have experience in working with families with multiple needs. Caseloads will not exceed 15 families per FSW if the caseload is all expectant mothers and families with infants. As the HFA program progresses and FSWs have combined caseload of expectant mothers, families with infants and toddlers and the frequency of visits decreases for some families, FSWs may have a caseload up to 25 families. Part time FSWs with a pro-rated caseload are permitted based upon the percentage of a full time employee they are working.

2. Healthy Families America Supervision

There should be one Supervisor for every five staff persons. A ratio of 1:6 is permissible, but 1:5 is optimal. If the Supervisor and Program Manager roles are staffed by the same person, adequate time to support each role must be provided for in a supervision plan. The HFA agency must demonstrate a commitment to adequate staffing to provide the level of supervision for direct service staff required by HFA standards. Supervisors provide a minimum of 1.5 hours of direct supervision to each FAW and FSW each week. Supervisors and Program Managers must also receive regular supervision with supervisors receiving supervision at a minimum of once per month. Program managers are also to receive supervision.

3. Additional Staffing Structure for Healthy Families America

All certified MIECHV providers are required to enter extensive data into the required web based databases. HFA providers are permitted to use additional support staff outside of the positions listed in above to support data entry, billing, community outreach and other activities and these staff must be identified with hourly allocations in the proposal.

4. Provider Orientation and Training

HFA Program Managers, Supervisors, FAWs and FSWS are required to attend training to be held in Rhode Island or the Northeast region. HFA provides separate training sessions for the FAW and the FSW. Supervisors, FAWs, and FSWS are required to attend both trainings. In addition to the specific HFA trainings, staff is required to attend Growing Great Kids (GGK) training and HEALTH's MIECHV Orientation Training. GGK is the curriculum utilized in the delivery of HFA services in Rhode Island. Trainings will be held in Rhode Island or the Northeast region. Staff is required to attend the HFA model trainings, the GGK curriculum training, and HEALTH's MIECHV orientation training before any direct services may be provided to families.

5. Enrollment in Healthy Families America

Pregnant women may enroll in HFA at any time in their pregnancy. Families with young children must receive an HFA assessment until the child is two weeks of age. Pregnant women and families may have more than one child. All agencies providing HFA are strongly encouraged to enroll women parentally, before the birth of their child. There will be performance measures in HEALTH's MIECHV Program associated with the percentage of women enrolled prenatally that certified providers are required to achieve.

6. Healthy Families America Model Requirements

HFA is designed to work with pregnant women and families until a child is three years of age. Pregnant women and families with young children, through three months of age, may enroll. Direct services are provided by a FAW and a FSW. Services are initially provided weekly, then the frequency of visits decreases as the child ages. All services are provided under the framework of the 12 Critical Elements of HFA. Per HFA, "all affiliated and credentialed HFA programs adhere to these critical elements which provide the framework for program development and implementation. Staff is trained on the critical elements. Programs are credentialed based on adherence to the critical elements "

Submit a one year budget based on the following template in Excel format that does not go over the total amount for which you are applying. A budget must be submitted for each model and the total number of slots per model must be described. A detailed budget narrative must accompany each budget for each model. Food/drink is not an allowed cost.

Budget Template – Healthy Families America

| | | | |
|---|-------------------|----------------|-------|
| CATEGORY | | | |
| Total Number of Slots | 25 | | |
| Community | West Warwick | | |
| PERSONNEL | Hourly Rate | Total # of Hrs | Total |
| Program Manager | \$ | | \$ |
| Supervisor | \$ | | \$ |
| Family Assessment Worker(s) | \$ | | \$ |
| Family Support Worker(s) | \$ | | \$ |
| (List individually) | | | |
| FRINGE BENEFITS | Fringe % Rate | | |
| Program Manager | | \$ | |
| Supervisor | | \$ | |
| Family Assessment Worker(s) | | \$ | |
| Family Support Worker(s) | | \$ | |
| (List individually) | | | |
| IN-STATE TRAVEL (\$.555 per mile X ____ miles) | \$ | | |
| OUT-OF-STATE TRAVEL | \$ | | |
| OFFICE SUPPLIES | \$ | | |
| TELEPHONE/INTERNET/FAX | \$ | | |
| EDUCATIONAL MATERIALS | \$ | | |
| PRINTING/COPYING | \$ | | |
| EQUIPMENT | \$ | | |
| POSTAGE | \$ | | |
| OTHER/SPECIFY (See Below) | | | |
| OTHER/FIXED HFA MODEL FEES Application Fee (\$500) Annual Fee (\$1,350) | \$1,850.00 | | |
| OTHER/HFA/GGK Fixed Training Costs = \$8,526 | \$8,526.00 | | |
| INDIRECT COSTS (____%) | | | |
| TOTAL REQUEST | | | |

Required 10% Match: Include the amount of the required 10% match, the source of the match (it must be non-federal sources), and a description of how the match will be used to support program goals and objectives. This information must be included in the budget and budget narrative.

Healthy Families America Sample Job Descriptions

Note regarding all staff for Healthy Families America: Direct service staff for HFA should be hired because of their personal characteristics that support their education and experience, per the Critical Elements requirements of HFA.

Job Description: Healthy Families America Family Assessment Worker

Primary Responsibilities

- Interviewing/ conducting the HFA assessment tool with parents to determine eligibility for home visiting services
- Make referrals to appropriate community-based agencies, depending on a family's needs
- Enter home visiting data, if necessary
- May be responsible for reviewing hospital or referral records in accordance with confidentiality policies
- Participate in required trainings and the Home Visiting Network
- Treat families equitably and fairly
- Attend HFA trainings as appropriate

Staff Characteristics and Experience

- Experience working in with community agencies, including implementing referral processes
- Experience working with culturally diverse communities/ families and the ability to be culturally sensitive and appropriate
- Strong interpersonal skills with experience engaging high risk populations
- Maturity and experience working with families
- Proficient in the first language of the communities where services are being provided if a community is bi-lingual
- Good organizational and writing skills; task oriented; behavior supports beginning and completing a project
- Ability to work collaboratively with other service providers
- May require flexible availability

Education and Experience Requirements

- Must have a minimum of an Associate Degree in Human Services, Child Developments or related field, with a minimum of two (2) years experience providing services to and/ or engaging families with infants and toddlers in services. Must have experience working with families with multiple needs.

Job Description: Healthy Families America Family Support Worker

Primary Responsibilities

- Initiating and maintaining regular contact with pregnant women and families, primarily in their homes
- Establish trusting, non judgmental relationships with families
- Provide prenatal and other health education
- Assist in strengthening the parent-child relationship
- Assist parents in improving their skills to optimize the home environment
- Responsible for assisting families in establishing goals and a plan for accomplishing those goals
- Identify and refer to other support services in the community; Assist in making and attending health and human service appointments, including activities related to educational and employment goals
- Participate in required trainings and the Home Visiting Network
- Do data entry, as necessary
- Treat families equitably and fairly
- Attend HFA trainings as appropriate

Staff Characteristics and Experience

- Maturity and experience working with children (0-3 years of age) and their families
- Experience working with culturally diverse communities/ families and the ability to be culturally sensitive and appropriate
- Demonstrates motivation and ability to learn and practice basic supportive skills
- Knowledge of community resources
- Ability to handle stressful situations
- Strong listening skills
- Knowledge of infant and child development
- Strong interpersonal skills with experience engaging high risk populations
- Proficient in the first language of the communities where services are being provided if a community is bi-lingual
- Good organizational and writing skills
- Ability to work collaboratively with other service providers
- Enjoys and functions appropriately with long-term, ongoing projects; does not need immediate feedback or results for personal validation
- Ability to relate to families from a strength based model; ability to approach families from a family-centered service model
- Flexible availability

Education and Experience Requirements

- Must have a minimum of a Bachelors Degree in Human Services, Child Development, Education or related field, with a minimum of three years of public health or community development experience. Must have experience working with families with multiple needs.

Appendix 3: Parents as Teachers

Program Model Overview

Theoretical Model

The PAT model is a voluntary, evidence-based home visiting model designed to ensure young children are healthy, safe, and ready to learn.

Program Model Components

The PAT model has four components, each closely related and integrated: personal visits, group connections, child screenings, and resource network. Together, these four components create a cohesive package of services with four primary goals:

1. Increase parent knowledge of early childhood development and improve parenting practices.
2. Provide early detection of developmental delays and health issues.
3. Prevent child abuse and neglect.
4. Increase children's school readiness and school success.

Target Population

PAT does not have eligibility requirements for participants. Individual programs select the specific characteristics of the target population they plan to serve.

PAT programs can serve children and their families from pregnancy through kindergarten entry. Through MIECHV funding in Rhode Island, PAT will enroll pregnant women and families with infants through six months of age and provide services until a child turns three.

Where to Find Out More

Parents as Teachers National Center, Inc.
Attn: Public Information Specialist
2228 Ball Drive
St. Louis, Mo. 63146
Telephone: 314-432-4330
Toll-free telephone: 1-866-728-4968
Fax: 314-432-8963
Website: www.parentsasteachers.org

Specific Requirements of Parents as Teachers in Rhode Island

PAT requires a minimum of 12 slots to become a PAT affiliate.

1. Specific Staff Qualifications

PAT utilizes Parent Educators to provide direct home visiting services to pregnant women and families. Parent Educators are supported by a Supervisor, who may supervise no more than 12 Parent Educators at any time.

Supervisor

Must be Masters level, meet the requirements of a qualified licensed professional and have a minimum of three to five years working with young children and their families as well as supervision of direct service staff. Discipline specific supervision should be provided in accordance with HEALTH practice acts.

Parent Educators

Must have a minimum of a Bachelors Degree in Human Services, Child Development, Education or related field, with a minimum of three years of public health or community development experience working with young children and/ or parents. Part time Parent Educators with a pro-rated caseload are permitted based upon what percentage of a full time employee they are working.

2. Parents as Teachers Supervision

PAT supervisors must provide a minimum of two hours of individual reflective supervision each month, in addition to a minimum of two hours of staff meetings each month. HEALTH recommends providing a minimum of four hours of individual reflective supervision each month and four hours of staff meetings and case management each month.

3. Additional Staffing Structure for Parents as Teachers

All certified MIECHV providers are required to enter extensive data into the required web based database. PAT providers are permitted to use additional support staff outside of the positions listed above to support data entry, billing, community outreach and other activities and these staff must be identified with hourly allocations in the proposal.

4. Provider Orientation and Training

Supervisors and Parent Educators must attend PAT Foundational and Model Implementation trainings. In addition to the specific PAT trainings, staff is required to attend Life Skills Progression (LSP) training and HEALTH's MIECHV Orientation Training. LSP is the curriculum utilized in the delivery of PAT services in Rhode Island. Trainings will be held in Rhode Island or the Northeast region. Staff is required to attend the PAT model trainings, the LSP curriculum training, and HEALTH's MIECHV orientation training before any direct services may be provided to families.

5. Enrollment in Parents as Teachers

Pregnant women may enroll in PAT at any time in their pregnancy. Families with young children may enroll in PAT up until the child is six months of age. Pregnant women and families may have more than one child. All agencies providing PAT are strongly encouraged to enroll women parentally, before the birth of their child. There will be performance measures in HEALTH's MIECHV Program associated with the percentage of women enrolled prenatally that certified providers are required to achieve.

6. Parents as Teachers Model Requirements

Through the MIECHV Program funding, pregnant women and families with young children, through six months of age, may enroll in PAT in designated communities. Services are provided by Parent Educators and home visits will be provided weekly during pregnancy and early in the child's life, then decrease in frequency as the child ages. Through MIECHV Program funding, PAT services will be provided until the child is three years of age. All certified MIECHV Program providers that are providing PAT must implement the program per the PAT Essential Requirements and curriculum.

Please submit a one year budget based on the following template in Excel format that does not go over the total amount for which you are applying. A budget must be submitted for each model and the total number of slots per model must be described. A detailed budget narrative must accompany each budget for each model. Food/drink is not an allowed cost.

Budget Template- Parents as Teachers

| | | | |
|--|---------------|----------------|-------|
| CATEGORY | | | |
| Total Number of Slots | 72 (Total) | | |
| Community | Providence | | |
| PERSONNEL | Hourly Rate | Total # of Hrs | Total |
| Supervisor | \$ | | \$ |
| Parent Educator(s) (List-Individually. There must be one parent educator for every 12 families) | \$ | | \$ |
| FRINGE BENEFITS | Fringe % Rate | | |
| Supervisor | | \$ | |
| Parent Educators(s) (List individually) | | \$ | |
| IN-STATE TRAVEL (\$.555 per mile X ____ miles) | \$ | | |
| OUT-OF-STATE TRAVEL | \$ | | |
| OFFICE SUPPLIES | \$ | | |
| TELEPHONE/INTERNET/FAX | \$ | | |
| EDUCATIONAL MATERIALS | \$ | | |
| PRINTING/COPYING | \$ | | |
| EQUIPMENT | \$ | | |
| POSTAGE | \$ | | |
| OTHER/SPECIFY (See Below) | | | |
| OTHER/FIXED PAT Program Support Fees (\$3,500) | \$3,500.00 | | |
| OTHER/Staff Professional Development Costs (\$100 per staff person annually) 1,200 for every 12 families | \$ | | |
| Other/Group Connections Meetings (\$75 X 12 meetings) | \$900.00 | | |
| Other/Fixed PAT/LSP Training Costs \$2,060.00 for every 12 families | \$ | | |
| INDIRECT COSTS (____%) | | | |
| TOTAL REQUEST | | | |

Required 10% Match: Include the amount of the required 10% match, the source of the match (it must be non-federal sources), and a description of how the match will be used to support program goals and objectives. This information must be included in the budget and budget narrative.

Parents as Teachers Sample Job Description: Parent Educator

This is a multi-faceted and demanding position.

- Must have a minimum of a Bachelors Degree in Human Services, Child Development, Education or related field, with a minimum of three years of public health or community development experience working with young children and/ or parents and previous supervised work experience with young children and/or parents.
- Be highly organized and accountable.
- Be an independent, self-motivated worker.
- Be able to learn and understand and incorporate the three roles of a parent educator: partnering, facilitating, and reflecting into daily practice with families.
- Be able to establish rapport with families and empower them by building on their strengths.
- • Be competent with computer skills; including web browsing, e-mail, Internet, and word processing.

Duties and Responsibilities of a Parent Educator

- Become knowledgeable about the Parents as Teachers model including the Essential Requirements necessary for model fidelity.
- Conduct personal visits (50-60 minutes) using the Parents as Teachers curriculum on the required visit schedule
- Plan the visit, gather materials, travel, conduct the visit, and clearly document the visit.
- Provide parent group connections focusing on a minimum of one of the following areas of emphasis: parent-child interaction, development-centered parenting, or family well-being.
- Complete required child and family screenings
- Develop and maintain a community resource network in order to be able to link families with them as needed.
- Maintain and submit in a timely way all required family and program documentation.
- Organize and inventory supplies/materials, etc.
- Meet at a minimum of twice monthly with supervisor for reflective supervision sessions.
- Help parents and children transition to other services as needed, to preschool, or to kindergarten.
- Complete annually required competency-based professional development hours in order to remain a certified Parents as Teachers parent educator (see Parents as Teachers Core Competencies for more details).

Appendix 4: Standardized tools for use in the Maternal, Infant and Early Childhood Home Visiting Program

All certified Maternal, Infant and Early Childhood Home Visiting Program providers are required to use these tools, in addition to other model specific tools that may be required as specific time periods as mandated by HEALTH and/ or the specific models. HEALTH will work with certified providers to provide these tools directly to agencies. The individual evidence based models may use additional required tools that are not mentioned below.

Ages and Stages Questionnaire (ASQ-3)

The Ages and Stages Questionnaire is a tool that measures a child's performance in five developmental subscales. It is based on parent report.

Ages and Stages Questionnaire: Social Emotional (ASQ:SE)

The Ages and Stages Questionnaire: Social Emotional measures a child's social behavior, emotion regulation and emotional well-being. It is based on parent report.

Alcohol Use Disorders Identification Test (AUDIT)

The Alcohol Use Disorders Identification Test screens for hazardous/ risky drinking, harmful drinking or alcohol dependence. It is a ten item self-report screening questionnaire.

Drug Abuse Screening Test (DAST-10)

The Drug Abuse Screening Test screens for use/ abuse of illicit drugs. The self-report screening questionnaire identifies individuals who are abusing drugs and the degree of problems related to drug use and misuse.

Patient Health Questionnaire-9 (PHQ-9)

The Patient Health Questionnaire-9 measures depressive symptomology and is based on mother/ caregiver's self report.

Home Observation for Measurement of the Environment Inventory (HOME)

The Home Observation for Measurement of the Environment Inventory measures the quality and quantity of stimulation and support available to a child in the home environment. It is composed of 45 items among six subscales.

Life Skills Progression (LSP) (For use by PAT affiliates only): The Life Skills Progression is an outcome and intervention planning instrument which is helpful in assessing the strengths and needs of families.

Appendix 5: Mandated Rhode Island MIECHV Program Benchmarks

| Benchmark I. Improved Maternal and Newborn Health | |
|--|--|
| Prenatal Care | |
| Proposed Indicator | Percentage of pregnant women enrolled in the program that received an “adequate” or “adequate plus” number of prenatal care visits from entry into the program to delivery of child as measured by the Kotelchuck index |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase the percentage of enrolled pregnant women who received “adequate” or “adequate plus” number of prenatal care visits from entry into the program to delivery of index child as measured by the Kotelchuck Index from Year 1 baseline to Year 3 benchmark reporting period |
| Measurement Tool | Dates of prenatal visits to be collected using structured interview question during prenatal period. Using the Kotelchuck Index as a reference, determine whether patient receives “adequate” or “adequate plus” prenatal care. Number of expected visits are separated into four categories, inadequate (less than 50%), intermediate (50-79%), adequate (80-109%), adequate plus (110% or more). Prenatal visits will be tracked from program enrollment to delivery of index child and compared to expected number of “adequate” or “adequate plus” visits during the same period if client followed the recommended schedule as defined by the Kotelchuck Index. Enrolled women will be asked the date of their last prenatal appointment (excluding visits to the emergency room); what doctor/ healthcare facility they saw for their last appointment; when their next scheduled prenatal appointment is scheduled. |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. This information will be documented on the Maternal and Child Home Visiting form. |
| Population Assessed | Pregnant Women |
| Sampling Plan | None (all pregnant women will be included) |
| Data Collection | Standard interview questions asked at time of enrollment and initial and subsequent prenatal home visits/assessments. Responses will be entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Women identified as pregnant at time of enrollment; Pregnant women's use of prenatal care during pregnancy. The calculation will be determined by dividing the number of women enrolled prenatally that received the Kotelchuck index's “adequate” or “adequate plus” number of prenatal care visits from entry into the program by the total number of pregnant women enrolled |
| Preconception Care | |
| Proposed Indicator | Percentage of women enrolled in the program that discussed preconception health with a health care worker during a health care visit within 6 months postpartum |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase the percentage of women enrolled in program that discussed preconception health with a health care worker during a health care visit within 6 months postpartum from Year 1 baseline to Year 3 benchmark reporting period |

| | |
|------------------------------|---|
| Measurement Tool | Standard interview questions administered at each home visit through 6 months postpartum. Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. At each visit through 6 months postpartum, mothers will be asked about the content of their postpartum visits, including preconception health; this information will be documented on the Maternal and Child Home Visiting form. |
| | Enrolled women will be asked if they have seen a healthcare professional since their last home visit. If enrolled mother has seen a healthcare professional since her last home visit, home visitor will ask if the healthcare professional talked about any of the following: taking multi-vitamins, diabetes, health and nutrition, exercise, using alcohol, tobacco and/ or drugs, counseling for healthy behaviors, pregnancy intention and planning. |
| Validity of Tool | Information is collected through skilled conversations with mothers using semi-structured interview protocol administered at each home visit through 6 months postpartum |
| Population Assessed | Postpartum women |
| Sampling Plan | None (all postpartum women will be included) |
| Data Collection | Data will be collected at enrollment and at each home visit until 6 months postpartum and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Exclude families still pregnant at the end of the project period (baseline year); Exclude families enrolled for more than one year. The calculation will be determined by dividing the number of women enrolled delivering a live birth that discussed preconception health with a health care worker during a health care visit within 6 months postpartum by the total number of women enrolled delivering a live birth. |
| Inter-birth Intervals | |
| Proposed Indicator | Percentage of women who enroll in the program prenatally through one month postpartum that are using an appropriate form of birth control at 6 months postpartum |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase the percentage of enrolled women who are using an appropriate form of birth control while in the program, from Year 1 baseline to Year 3 benchmark reporting period. Appropriate forms of birth control are defined as effective medically approved family planning methods and services, as approved by the Federal Food and Drug Administration. All women should receive counseling from their provider so that they are able to make an informed decision on the choice and continued use of family planning methods and services. |
| Measurement Tool | Standard interview questions administered at each home visit through 6 months postpartum. Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. At each visit through 6 months postpartum, mothers will be asked about their use of an appropriate form of birth control; this information will be documented on the Maternal and Child Home Visiting form. For women enrolled in Nurse-Family Partnership, this information is also collected on the model's Demographics form, including at 6 months postpartum. Enrolled women will be asked if they are currently using birth control or are still using birth control. If enrolled mother is using birth control, she will be asked what type of birth control she is using and if she is happy with the method she is using. |

| | |
|---|--|
| Validity of Tool | Information is collected through skilled conversations with mothers using semi-structured interview protocol administered at each home visit through 6 months postpartum |
| Population Assessed | Postpartum women |
| Sampling Plan | None (all postpartum women will be included) |
| Data Collection | Data will be collected at enrollment and at each home visit until 6 months postpartum and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Exclude families still pregnant at the end of the project period (baseline year); Exclude families enrolled for more than one year. The calculation will be determined by dividing the number of women enrolled delivering a live birth that were using an appropriate form of birth control at 6 months postpartum by the total number of women enrolled delivering a live birth. |
| Screening for Maternal Depressive Symptoms | |
| Proposed Indicator | Percentage of women enrolled in the program that have been screened for maternal depressive symptoms within 4 weeks postpartum using the Patient Health Questionnaire-9 (PHQ-9) |
| Indicator Type | Process Measure |
| Measurable Objective | Increase or maintain the percentage of women enrolled in the program that have been screened for maternal depressive symptoms once with 4 weeks postpartum using the Patient Health Questionnaire-9 (PHQ-9) from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Patient Health Questionnaire-9 (PHQ-9) |
| Validity of Tool | The Patient Health Questionnaire-9 (PHQ-9) is the nine item depression scale of the Patient Health Questionnaire. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff. The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). |
| Population Assessed | Postpartum women |
| Sampling Plan | None (all postpartum women will be included) |
| Special Considerations | Home visitors are trained to use the Patient Health Questionnaire-9 (PHQ-9) |
| Data Collection | Data regarding maternal depressive symptoms using the Patient Health Questionnaire-9 (PHQ-9) is collected once within 4 weeks postpartum. Data will be entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Women screened for maternal depressive symptoms (yes/no) and date. The calculation will be determined by dividing the number of enrolled postpartum women screened for maternal depressive symptoms using the Patient Health Questionnaire-9 (PHQ-9) within four weeks postpartum by the total number of enrolled women who are four weeks postpartum. |
| Breastfeeding | |
| Proposed Indicator | Percentage of women enrolled who report exclusively breastfeeding their index child at 12 weeks of age |

| | |
|--------------------------------------|---|
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase percentage of enrolled women who report exclusively breastfeeding their index child at 12 weeks of age, from Year 1 baseline to Year 3 benchmark reporting period. Exclusive breastfeeding is defined as an infant receiving only breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines. Expressed breast milk and donor milk count as breast milk. |
| Measurement Tool | Standard interview question to determine breastfeeding status. |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at each visit until the index child is 12 weeks of age. Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. At each visit, mothers with index children through 12 weeks of age will be asked to report their child's feeding type; this information will be documented on the Maternal and Child Home Visiting form. Enrolled women will be asked if they are breastfeeding/ still breastfeeding their baby; have they introduced their baby to anything other than breastmilk, for example, water, juice, formula, cereal; if they stopped breastfeeding they will be asked why they stopped; if they stopped breastfeeding, they will be asked when they stopped. |
| Population Assessed | Postpartum women |
| Sampling Plan | None (all postpartum women will be included) |
| Data Collection | Data regarding breastfeeding status (breastfeeding exclusively, with supplements, or not at all) is collected at each visit until index child is 12 weeks of age, and entered into Home Visiting database. Data will be collected in days and weeks. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Exclude women still pregnant at the end of the project period; Breastfeeding status when index child is 12 weeks of age; Exclude families whose index child is under three months of age. The calculation will be determined by dividing the number of enrolled women who are exclusively breastfeeding their infants at 12 weeks of age by the total number of enrolled women with index children at 12 weeks of age. |
| Adequacy of well-child visits | |
| Proposed Indicator | Percentage of index children who are up-to-date on a schedule of age-appropriate preventative and primary health care according to RI's Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule for well child care visits for children 6 through 18 months of age, while enrolled in the program |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase percentage of index children who are up-to-date on a schedule of age-appropriate preventative and primary health care according to RI's Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule for well child care visits for children 6 through 18 months of age from Year 1 baseline to Year 3 benchmark reporting period. RI's EPSDT well child care visit schedule requires visits 6, 9, 12, 15 and 18 months of age. |
| Measurement Tool | Standard interview question to determine status of well child visits. |

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| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at home visits until the index child is 18 months of age/ and or has had their 18 month well child care visit. At each visit until the index child is about 18 months of age, mothers/ families will be asked about well child care visits; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. For families enrolled in the Nurse-Family Partnership, data will also be collected on the model's Infant Health Care Form. Enrolled families will be asked if they taken their child to their pediatrician since their last home visit; if it was a scheduled well child visit; if it was not a well child visit, why the child went to the pediatrician. |
| Population | Index child |
| Assessed | |
| Sampling Plan | None (all index children will be included) |
| Data Collection | Data regarding well child visits is collected at each visit, and entered into home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Exclude enrolled women who are still pregnant at the end of the project period; Number of index children enrolled in the program; Ages of index children enrolled in the program; Number of visits that index children have to primary care providers for well child care visits through 18 months of age. The calculation will be determined by dividing the number of index children who receive the recommended schedule of well child visits through 18 months of age by the total number of index children who are 18 months of age. |
| Maternal and Child Health Insurance Coverage | |
| Proposed Indicator | Percentage of mothers and index children who obtain and/ or maintain health insurance within three months of program enrollment. |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase in the percentage of mothers and index children that obtain and/ or maintain health insurance within three months of program enrollment from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Standard interview question to determine status of health insurance |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. At each visit, families will be asked about the mother's and index child's health insurance status; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. Enrolled women will be asked if they have health insurance or have obtained health insurance since their last home visit; if enrolled woman has health insurance, she will be asked her insurance type. Enrolled women will be asked if their child has health insurance or has obtained health insurance since the last home visit; if child has health insurance, mother will be asked her insurance type. Home visitor will ask to see copy of insurance card(s). |
| Population Assessed | Enrolled mothers and index children |
| Sampling Plan | None (all enrolled mothers and index children will be included) |
| Special Considerations | Separate data will be collected for both maternal and child health insurance and aggregated for this construct |

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| Data Collection | Data regarding maternal and child health insurance is collected at each visit, and entered into home visiting database. |
| Data Analysis Plan | <p>Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrolled mothers and index children in the program by insurance status; Enrollment from the start of the project period; Status of health insurance at three months post enrollment.</p> <p>The calculation will be determined by dividing the number of enrolled mothers and index children without health insurance who enrolled in a health insurance plan within three months of enrollment by the total number of enrolled mothers and index children who did not have health insurance at enrollment plus the number of enrolled mothers and index children that had health insurance at time of enrollment who maintained their health insurance plan at three months post enrollment by the total number of enrolled mothers and index children who health insurance at time of enrollment but did not have health insurance at three months post enrollment.</p> |
| Maternal Health Insurance Coverage* (HEALTH will collect this data and report its outcome as part of a larger construct that includes child health insurance) | |
| Proposed Indicator | Percentage of enrolled women (mothers) with health insurance |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase percentage of women without health insurance who attain health insurance within three months of program enrollment from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Standard interview question to determine status of health insurance |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. At each visit, mothers will be asked about their health insurance status; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. |
| Population Assessed | Enrolled women (Mothers) |
| Sampling Plan | None (all women enrolled will be included) |
| | Data regarding maternal health insurance is collected at each visit, and entered into home visiting database. |
| Data Analysis Plan | <p>Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Women in the program by insurance status; Enrollment from the start of the project period, exclude women who are still pregnant at the end of the project period; Status of health insurance at the end of the project period.</p> <p>The calculation will be determined by dividing the number of enrolled women without health insurance who enrolled in a health insurance plan within 3 months by the total number of enrolled women who did not have health insurance at enrollment.</p> |
| Child Health Insurance Coverage* (HEALTH will collect this data and report its outcome as part of a larger construct that includes maternal health insurance) | |
| Proposed Indicator | Percentage of index children with health insurance |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase or maintain percentage of index children without health insurance who attain health insurance within three months of program enrollment from Year 1 baseline to Year 3 benchmark reporting period. |

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| Measurement Tool | Standard interview question to determine status of health insurance |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. At each visit, families will be asked about the index child's health insurance status; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. |
| Population Assessed | Index child |
| Sampling Plan | None (all index children will be included) |
| Data Collection | Data regarding child health insurance is collected at each visit, and entered into home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Index children in the program by insurance status; |
| | Enrollment from the start of the project period; Status of health insurance at the end of the project period. The calculation will be determined by dividing the number of enrolled children without health insurance who enrolled in a health insurance plan within three months of enrollment by the total number of enrolled children who did not have health insurance at enrollment. |
| Pre and post natal use of alcohol* (HEALTH will collect data for this construct, but report on tobacco use) | |
| Proposed Indicator | Percentage of mothers enrolled in the program who score positive on the Alcohol Use Disorders Identification Test (AUDIT) that receive a brief intervention and/ or who receive referrals |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of mothers enrolled in the program who score positive on the Alcohol Use Disorders Identification Test (AUDIT) and who receive either a brief intervention or referrals, from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | The AUDIT was developed to screen for hazardous (or risky) drinking, harmful drinking or alcohol dependence. It is a ten item screening questionnaire with three questions on the amount and frequency of drinking, three questions on alcohol dependence and four questions on problems caused by alcohol. The AUDIT was developed and evaluated over a period of two decades, and it has been found to provide an accurate measure of risk across gender, age, and cultures. The AUDIT has been translated into Spanish, French and several other languages. |
| Validity of Tool | The AUDIT, when incorporated in a health risk screening questionnaire, is a reliable and valid self-administered instrument to identify at-risk drinkers and alcohol dependency. The percentile of identifiable at-risk and dependent alcohol drinker's range from 0.80 to 0.90. |
| Population Assessed | Mothers |
| Sampling Plan | None (all enrolled mothers will be included) |
| Special Considerations | Home visitors are trained to use the Alcohol Use Disorders Identification Test. |
| Data Collection | Mothers will be screened for alcohol using the AUDIT. Baseline data results of the screen will be entered into the home visiting database. Brief alcohol use interventions and/ or referrals will be collected minimally at enrollment, prenatally at 36 weeks and at one year enrollment. |

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| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Mothers screened for alcohol using the AUDIT (yes/no) and date. The calculation will be determined by dividing the number of mothers who score positive on the AUDIT that received a brief intervention and/ or referrals by the total number of enrolled mothers who scored positive on the AUDIT. |
| Pre and post natal use of illicit drugs* (HEALTH will collect data for this construct, but report on tobacco use) | |
| Proposed Indicator | Percentage of mothers enrolled in the program who score positive on the Drug Abuse Screening Test (DAST-10) that receive a brief intervention and/ or who receive referrals |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of parents enrolled in the program who score positive on the Drug Abuse Screening Test (DAST-10) and who receive either a brief intervention or referrals, from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement | The DAST was developed as a simple method of screening individuals for drug abuse. |
| Tool | The purpose of the DAST is to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs and to yield a quantitative index score of the degree of problems related to drug use and misuse. DAST scores are highly diagnostic with respect to a DSM diagnosis of psychoactive drug dependence. The DAST has been translated into Spanish. |
| Validity of Tool | An internal consistency coefficient of .92 was obtained for a sample of 256 drug/alcohol abuse clients. Adequate concurrent or convergent validity was reported to have been demonstrated by the fact that the DAST attained 85 percent overall accuracy in classifying clients according to DSM-III diagnosis, and also to have been demonstrated by significant correlations of the DAST scores with frequency of various types of drugs used during the preceding 12 months. The statistical significance of the DAST scores to distinguish between DSM-III diagnosed abuse "cases" from "non-cases" is reported evidence of discriminate validity. |
| Population Assessed | Mothers |
| Sampling Plan | None (all enrolled mothers will be included) |
| Special Considerations | Home visitors are trained to use the Drug Abuse Screening Test. |
| Data Collection | Parents enrolled in the program will be screened for illicit drugs. Baseline data results of the screen will be entered into the home visiting database. Brief illicit drug interventions and/ or referrals will be collected minimally at enrollment, prenatally at 36 weeks and at one year enrollment. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Mothers screened for illicit drugs that scored positive on the DAST-10 (yes/no) and date. The calculation will be determined by dividing the number of mothers who scored positive on the DAST-10 that received a brief intervention and/ or referrals by the total number of enrolled mothers who scored positive on the DAST-10. |
| Pre and post natal use of tobacco* (HEALTH will report on this construct) | |
| Proposed Indicator | Percentage of mothers enrolled in the program who smoke/ use tobacco products that receive a brief tobacco cessation intervention and/ or who receive referrals |
| Indicator Type | Process measure |

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| Measurable Objective | Increase or maintain the percentage of parents enrolled in the program who smoke and who receive a brief tobacco cessation intervention and/ or who receive a referral, from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Standard interview question to determine status of smoking. |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. At visits, mothers will be asked if they are smoking/ using tobacco products; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. Enrolled mothers will be asked if they smoke and/ or use tobacco products. If they do smoke/ use tobacco, if they want to stop. If mother is not interested in quitting smoking/ tobacco home visitor will provide information on the benefits that quitting can have on herself, her child and her family and the importance of quitting. If mother is interested in quitting smoking/ tobacco, home visitor will make a referral to cessation services with the mother and provide information on cessation services. Cessation service referral will be documented. |
| Population Assessed | Mothers |
| Sampling Plan | None (all enrolled mothers will be included) |
| Data Collection | Mothers will be screened for tobacco use. Baseline data results of the screen will be entered into the home visiting database. Brief tobacco cessation interventions and/ or referrals will be captured in the home visiting database. Brief tobacco cessation interventions and/ or referrals will be collected minimally at enrollment, prenatally at 36 weeks and at one year enrollment. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Mothers screened for use of tobacco (yes/no) and date. The calculation will be determined by dividing the number of mothers who smoked that received a brief tobacco cessation intervention and/ or referrals by the total number of enrolled mothers who smoked. |
| Benchmark II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits | |
| Decrease in visits for children to the emergency department from all causes | |
| Proposed Indicator | Percentage of visits by children enrolled in the program to the emergency department from all causes |
| Indicator Type | Outcome Measure |
| Measurable Objective | Decrease in percentage of visits by children enrolled in the program to the emergency department from all causes during their first year of program enrollment by comparing cohort 1 to cohort 2. |
| Measurement Tool | Standard interview question to determine visits by children enrolled in the program to the emergency department from all causes. |

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| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. At visits, mothers/ caregivers will be asked if the index child has visited the emergency room since the previous home visit. If so, the date of the visit and reason for the visit will be documented; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. Mothers will be asked if they or their child has gone to the emergency room or to a healthcare facility other than their own doctor or their child's pediatrician since their last home visit. If the mother and/ or child have gone to the emergency room or to a healthcare facility other than their own doctor or their child's pediatrician; they will be asked when they went, why they went and where they went. |
| Population Assessed | Index child |
| Sampling Plan | None (all index children will be included) |
| Data Collection | Data regarding visits to the emergency department for all causes is collected at each visit and entered into home visiting database. Data will be reported by age: 0-12 months and 13-36 months. Data will be collected at 6 months, 12 months, 18 months, 24 and 36 months. |
| Data Analysis Plan | Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Visits by index children enrolled in the program to the emergency department from all causes (yes/no) and date. |
| | The calculation will be determined by dividing the number of visits to the emergency room by index children enrolled in the program for one year in each cohort (cohort 1 and cohort 2) by the total number of index children enrolled in the program for one year in each cohort (cohort 1 and cohort 2). The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts. |
| Decrease in visits for mothers to the emergency department from all causes | |
| Proposed Indicator | Visits by mothers enrolled in the program to the emergency department from all causes |
| Indicator Type | Outcome Measure |
| Measurable Objective | Decrease in percentage of visits by mothers enrolled in the program to the emergency department from all causes during their first year of program enrollment by comparing cohort 1 to cohort 2. |
| Measurement Tool | Standard interview question to determine visits by mothers enrolled in the program to the emergency department from all causes. |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. At visits, mothers will be asked if they have visited the emergency room since the previous home visit; if so, the date they visited the emergency room and the reason; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. Mothers will be asked if they or their child has gone to the emergency room or to a healthcare facility other than their own doctor or their child's pediatrician since their last home visit. If the mother and/ or child have gone to the emergency room or to a healthcare facility other than their own doctor or their child's pediatrician; they will be asked when they went, why they went and where they went. |

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| Population Assessed | Mother |
| Sampling Plan | None (all enrolled mothers will be included) |
| Data Collection | Data regarding visits to the emergency department for all causes is collected at each visit and entered into home visiting database. |
| Data Analysis Plan | Mothers who enrolled in Year 1 of the program will be cohort 1. Mothers enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Visits by enrolled mothers in the program to the emergency department from all causes (yes/no) and date. The calculation will be determined by dividing the number of visits to the emergency room by enrolled mothers in the program for one year in each cohort (cohort 1 and cohort 2) by the total number of enrolled mothers in the program for one year in each cohort (cohort 1 and cohort 2). The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts. |
| Increase in information provided or training of participants on prevention of child injuries | |
| Proposed Indicator | Percentage of mothers/caregivers provided information and/or trained on specific topics such as safe sleep, shaken baby syndrome, passenger safety, etc. while enrolled |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase percentage of mothers/caregivers provided information and/ or trained on specific topics such as safe sleep, shaken baby syndrome, passenger safety etc. while enrolled from Year 1 baseline to the Year 3 benchmark reporting period. |
| Measurement Tool | Home visiting database |
| Validity of Tool | Information on child injury prevention and/ or training provided to mothers/caregivers will be collected at each visit on a RI Maternal and Child Home Visiting form to be used by Healthy Families America and Parents as Teachers participants and on the Home Visit Encounter form for families enrolled in Nurse-Family Partnership. |
| Population Assessed | Mothers/Caregiver |
| Sampling Plan | None (all mothers/caregivers will be included) |
| Data Collection | Data regarding mothers and caregivers provided information and/ or trained on prevention of childhood injuries while enrolled will be documented and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; mothers/caregivers receiving health and safety training during visits (Yes/No); Health and safety topics reviewed. The calculation will be determined by assessing the numbers of enrolled mothers/caregivers provided information and/or trained on specific topics such as safe sleeping, shaken baby syndrome, passenger safety, etc. /total number of enrolled mothers/caregivers enrolled. |
| Decrease in incidence of child injuries requiring medical treatment | |
| Proposed Indicator | Percentage of index children enrolled in the program that required medical care outside of the index child's primary medical home for preventable and/ or avoidable injuries |
| Indicator Type | Outcome Measure |

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| Measurable Objective | Decrease in the percentage of index children enrolled in the program that required medical care outside of the index child's primary medical home for preventable and/ or avoidable injuries during their first year of program enrollment by comparing cohort 1 to cohort 2. |
| Measurement Tool | Standard interview question to determine index children enrolled in the program that required medical care outside of the index child's primary medical home for preventable and/ or avoidable injuries |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at each visit. At each visit, mothers will be asked if the index child has been injured and required medical treatment since the previous home visit and how the child was injured; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. Mothers will be asked if they or their child has gone to the emergency room or to a healthcare facility other than their own doctor or their child's pediatrician since their last home visit. If the mother and/ or child have gone to the emergency room or to a healthcare facility other than their own doctor or their child's pediatrician; they will be asked when they went, why they went and where they went. |
| Population Assessed | Index child |
| Sampling Plan | None (all index children will be included) |
| Data Collection | Data regarding visits requiring medical care outside of the index child's primary medical home for preventable and/ or avoidable injuries (all causes) is collected at each visit and entered into home visiting database. Data will be reported by age: 0-12 months, 13-36 months. |
| Data Analysis Plan | Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query |
| | using the following criteria: Enrollment from the start of the project period; Index children who have received medical care resulting from preventable/ avoidable injury during their first year of program enrollment in each cohort (cohort 1 and cohort 2). The calculation will be determined by dividing the number of index children who have received medical care resulting from preventable/ avoidable injury during their first year of program enrollment in each cohort (cohort 1 and cohort 2) by the total number of index children enrolled in the program for one year in each cohort (cohort 1 and cohort 2). The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts. |
| Decrease in reported suspected maltreatment of children in the program (screened but not necessarily substantiated) | |
| Proposed Indicator | Percentage of index children that were reported to the RI Department of Children Youth and Families (DCYF, the State's child welfare agency) for suspected maltreatment |
| Indicator Type | Outcome Measure |
| Measurable Objective | Decrease the percentage of index children that were reported to the RI Department of Children Youth and Families (DCYF, the State's child welfare agency) for suspected maltreatment during their first year of program enrollment by comparing cohort 1 to cohort 2. |
| Measurement Tool | RI DCYF Administrative Data |
| Validity of Tool | Not applicable |

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| Population Assessed | Index children |
| Sampling Plan | None (all index children will be included) |
| Data Collection | Data will be collected monthly from the RI Department of Children Youth and families. Data will be reported by age: 0-12 months and 13-36 months Data will be collected monthly |
| Data Analysis Plan | Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; the number of index children who were reported to DCYF for suspected maltreatment during their first year of program enrollment in each cohort (cohort 1 and cohort 2); types of maltreatment suspected; Action taken by DCYF. The calculation will be determined by dividing the number of index children that were reported to the RI Department for Children Youth and Families (DCYF, the State's child welfare agency) for suspected maltreatment during their first year of program enrollment in each cohort (cohort 1 and cohort 2) by the total number of index children enrolled in the program for one year in each cohort (cohort 1 and cohort 2). The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts. |
| <i>Decrease in reported substantiated, indicated maltreatment of children in the program (substantiated/ indicated/ alternative response victim)</i> | |
| Proposed Indicator | Percentage of index children that were reported to the RI Department of Children Youth and Families (DCYF, the State's child welfare agency) for substantiated, indicated maltreatment of children in the program (substantiated/ indicated/ alternative response victim) |
| Indicator Type | Outcome measure |
| Measurable Objective | Decrease the percentage of index children that were reported to the RI Department of Children Youth and Families (DCYF, the State's child welfare agency) for substantiated, indicated maltreatment (substantiated/indicated/alternative response victim) during their first year of program enrollment by comparing cohort 1 to cohort 2. |
| Measurement Tool | RI DCYF Administrative Data |
| Validity of Tool | Not applicable |
| Population Assessed | Index children |
| Sampling Plan | None (all index children will be included) |
| Data Collection | Data will be collected monthly from the RI Department of Children Youth and families. Data will be reported by age: 0-12 months and 13-36 months Data will be collected monthly |

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| Data Analysis Plan | <p>Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2.</p> <p>Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> <p>Enrollment from the start of the project period; the number of index children who were reported to DCYF for substantiated/ indicated maltreatment during their first year of program enrollment in each cohort (cohort 1 and cohort 2); types of maltreatment; Action taken by DCYF.</p> <p>The calculation will be determined by dividing the number of index children that were reported to the RI Department for Children Youth and Families (DCYF, the State's child welfare agency) for substantiated/ indicated maltreatment during their first year of program enrollment in each cohort (cohort 1 and cohort 2) by the total number of index children enrolled in the program for one year in each cohort (cohort 1 and cohort 2). The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts.</p> |
| Decrease in first time victims of maltreatment for children in the program | |
| Proposed Indicator | Percentage of index children enrolled in the programs that were first time victims of maltreatment |
| Indicator Type | Outcome measure |
| Measurable Objective | Decrease in the percentage of first time victims of maltreatment for index children during their first year of program enrollment by comparing cohort 1 to cohort 2. |
| Measurement Tool | RI DCYF Administrative Data |
| Validity of Tool | Not applicable |
| Population Assessed | Index children |
| Sampling Plan | None (all index children will be included) |
| Data Collection | <p>Data will be collected monthly from the RI Department of Children Youth and families.</p> <p>Data will be reported by age: 0-12 months and 13-36 months</p> <p>Data will be collected monthly</p> |
| Data Analysis Plan | <p>Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2.</p> <p>Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> |
| | <p>Enrollment from the start of the project period; the number of index children that were first time victims of maltreatment during their first year of program enrollment in each cohort (cohort 1 and cohort 2); types of maltreatment; Action taken by DCYF.</p> <p>The calculation will be determined by dividing the number of index children that were first time victims of maltreatment during their first year of program enrollment in each cohort (cohort 1 and cohort 2) by the total number of index children enrolled in the program for one year in each cohort (cohort 1 and cohort 2). The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts.</p> |
| Benchmark III. Improvements in School Readiness and Achievement | |
| Parent support for children's learning and development | |
| Proposed Indicator | Parent's support for children's learning and development as measured by the HOME |
| Indicator Type | Outcome measure |

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| Measurable Objective | Decrease the percentage of parents identified whose HOME scores on both subscales IV (Learning Materials) and V (Involvement) were below the healthy scores from when the index child is 6 months of age and again when the index child is 18 months of age (healthy scores are 4 for subscale IV and 1.7 for subscale V). |
| Measurement Tool | The Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell, & Bradley, 1984) is designed to measure the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment, child as a recipient of inputs from objects, events, and transactions occurring in connection with the family surroundings. The initial version of the Inventory is called the Infant/Toddler (IT) HOME. It is designed for use during infancy (birth to age three). It is composed of 45 items clustered into six subscales: 1) Parental Responsivity, 2) Acceptance of Child, 3) Organization of the Environment, 4) Learning Materials, 5) Parental Involvement, and 6) Variety in Experience. HOME scores will be documented on the HOME summary sheet. For families enrolled in Nurse-Family Partnership, HOME scores will also be documented on the Infant Health Care Form. |
| Validity of Tool | A binary-choice (yes/no) format is used in scoring items for the HOME. The alpha coefficients for the total scores are all above .90; and the inter-observer agreement for each measure is 90% or higher. The measure has been used throughout North and South America (including the Caribbean), in several European and Asian countries, in Australia, and in at least two African nations. A healthy score has been identified as the mean score minus one standard deviation. The mean score for subscale IV is 6.4 with a standard deviation of 2.4. The mean score for subscale V is 3.3 with a standard deviation of 1.6. |
| Population Assessed | Parents |
| Sampling Plan | None (all enrolled parents will be included) |
| Special Considerations | Home visitors are trained to use the HOME. |
| Data Collection | Data will be collected at 6 months and 18 months and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Families with index children at 6 and 18 months of age; Families screened using the HOME; subscales IV and V (yes/no) and date; Scores on the HOME assessment tool (subscales IV and V) when the index child |
| | is 6 months and 18 months of age. The calculation will be determined by dividing the percentage of enrolled families who scored below the healthy scores of 4 on subscale IV and 1.7 on subscale V on the HOME when the index child was 6 months of age and again at 18 months of age by the percentage of enrolled families who scored below the healthy scores of 4 on subscale IV and 1.7 on subscale V when the index child was 6 months of age but scored at or above the healthy levels on subscale IV and subscale V when the index child was 18 months of age. |
| Parent knowledge of child development and their child's development progress | |
| Proposed Indicator | Parent knowledge of child development and their child's developmental progress as measured by the HOME |
| Indicator Type | Outcome measure |

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| Measurable Objective | Decrease the percentage of parents identified whose total score on the HOME was below the healthy score of 23.3 when the index child was 6 months of age that again score below the total healthy score of 23.3 on the HOME when their index child is 18 months of age. |
| Measurement Tool | The Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell, & Bradley, 1984) is designed to measure the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment, child as a recipient of inputs from objects, events, and transactions occurring in connection with the family surroundings. The initial version of the Inventory is called the Infant/Toddler (IT) HOME. It is designed for use during infancy (birth to age three). It is composed of 45 items clustered into six subscales: 1) Parental Responsivity, 2) Acceptance of Child, 3) Organization of the Environment, 4) Learning Materials, 5) Parental Involvement, and 6) Variety in Experience. HOME scores will be documented on the HOME summary sheet. For families enrolled in Nurse-Family Partnership, HOME scores will also be documented on the Infant Health Care Form. |
| Validity of Tool | A binary-choice (yes/no) format is used in scoring items for the HOME. The alpha coefficients for the total scores are all above .90; and the inter-observer agreement for each measure is 90% or higher. The measure has been used throughout North and South America (including the Caribbean), in several European and Asian countries, in Australia, and in at least two African nations. A healthy score has been identified as the mean score minus one standard deviation. The total HOME mean score is 30.9 with a standard deviation of 7.6. |
| Population Assessed | Parents |
| Sampling Plan | None (all enrolled parents will be included) |
| Special Considerations | Home visitors are trained to use the HOME. |
| Data Collection | Data will be collected at 6 months and 18 months and entered into the home visiting database |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Families with index children at 6 and 18 months of age; Families screened using the HOME; (yes/no) and date; Total score on the HOME assessment tool when the index child is 6 months and 18 months of age. The calculation will be determined by dividing the percentage of enrolled families who scored below the healthy score of 23.3 on the HOME when the index child was 6 months of age and again when the index child is 18 months of age by the percentage of enrolled families who scored below the total healthy score of 23.3 when the index child was 6 months of age but scored at or above the total healthy score of 23.3 when the index child is 18 months of age. |
| Parenting behaviors and parent child relationship | |
| Proposed Indicator | Parenting behaviors and parent-child relationship, (e.g., discipline strategies and play interactions) as measured by the HOME |
| Indicator Type | Outcome measure |
| Measurable Objective | Decrease the percentage of parents identified whose HOME scores on both subscales I (Responsivity) and II (Acceptance) were below the healthy scores from when the index child is 6 months of age and again when the index child is 18 months of age (healthy scores are 5.8 for subscale I and 3.7 for subscale II). |

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| Measurement Tool | The Home Observation for Measurement of the Environment (HOME) Inventory (Caldwell, & Bradley, 1984) is designed to measure the quality and quantity of stimulation and support available to a child in the home environment. The focus is on the child in the environment, child as a recipient of inputs from objects, events, and transactions occurring in connection with the family surroundings. The initial version of the Inventory is called the Infant/Toddler (IT) HOME. It is designed for use during infancy (birth to age three). It is composed of 45 items clustered into six subscales: 1) Parental Responsivity, 2) Acceptance of Child, 3) Organization of the Environment, 4) Learning Materials, 5) Parental Involvement, and 6) Variety in Experience. HOME scores will be documented on the HOME summary sheet. For families enrolled in Nurse-Family Partnership, HOME scores will also be documented on the Infant Health Care Form. |
| Validity of Tool | A binary-choice (yes/no) format is used in scoring items for the HOME. The alpha coefficients for the total scores are all above .90; and the inter-observer agreement for each measure is 90% or higher. The measure has been used throughout North and South America (including the Caribbean), in several European and Asian countries, in Australia, and in at least two African nations. A healthy score has been identified as the mean score minus one standard deviation. The mean score for subscale I is 8.0 with a standard deviation of 2.2. The mean score for subscale II is 5.3 with a standard deviation of 1.6. |
| Population Assessed | Parents |
| Sampling Plan | None (all enrolled parents will be included) |
| Special Considerations | Home visitors are trained to use the HOME. |
| Data Collection | Data will be collected at 6 months and 18 months and entered into the home visiting database |
| Data Analysis Plan | Enrollment from the start of the project period; Families with index children at 6 and 18 months of age; Families screened using the HOME; subscales I and II (yes/no) and date; Scores on the HOME assessment tool (subscales I and II) when the index child is 6 months and 18 months of age. The calculation will be determined by dividing the percentage of enrolled families who scored below the healthy scores of 5.8 on subscale I and 3.7 on subscale II on the HOME when the index child was 6 months of age and again at 18 months of age by the percentage of enrolled families who scored below the healthy scores of 5.8 on subscale I and 3.7 on subscale II when the index child was 6 months of age but scored at or above the healthy levels on subscale I and subscale II when the index child was 18 months of age. |
| Parent emotional well-being or parenting stress | |
| Proposed Indicator | Percentage of women enrolled in the program that have been screened for maternal depressive symptoms within 4 weeks postpartum using the Patient Health Questionnaire-9 (PHQ-9) |
| Indicator Type | Process Measure |
| Measurable Objective | Increase or maintain the percentage of women enrolled in the program that have been screened for maternal depressive symptoms once with 4 weeks postpartum using the Patient Health Questionnaire-9 (PHQ-9) from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Patient Health Questionnaire-9 (PHQ-9) |

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| Validity of Tool | The Patient Health Questionnaire-9 (PHQ-9) is the nine item depression scale of the Patient Health Questionnaire. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff. The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). |
| Population Assessed | Postpartum women |
| Sampling Plan | None (all postpartum women will be included) |
| Special Considerations | Home visitors are trained to use the Patient Health Questionnaire-9 (PHQ-9) |
| Data Collection | Data regarding maternal depressive symptoms using the Patient Health Questionnaire-9 (PHQ-9) is collected once within 4 weeks postpartum. Data will be entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Women screened for maternal depressive symptoms (yes/no) and date. The calculation will be determined by dividing the number of enrolled postpartum women screened for maternal depressive symptoms using the Patient Health Questionnaire-9 (PHQ-9) within four weeks postpartum by the total number of enrolled women who are four weeks postpartum. |
| Child communication, language and emergent literacy | |
| Proposed Indicator | Index children screened in Communication as measured by the Ages and Stages Questionnaire and referred and evaluated as appropriate |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of index children who screen below the cutoff score of 15.64 in the Communication section of the ASQ at 12 months who are referred and evaluated comparing cohort 1 to cohort 2. |
| Measurement Tool | Ages and Stages Questionnaire (ASQ) |
| Validity of Tool | According to the developers, the ASQ has been extensively evaluated for reliability and validity. The ASQ has been found to be a reliable and valid tool for measuring children's performance in five developmental domains. Combined findings across years indicate overall agreement across questionnaires to be 83 percent (Squires, Potter & Bricker, 1999). Cutoff points were derived by subtracting 2 standard deviations from the mean for each area of development. Scores will be documented on the scoring sheet that accompanies the Ages and Stages Questionnaire. For families enrolled in Nurse-Family Partnership, ASQ scores will also be documented on the Infant Health Care Form. |
| Population Assessed | Index children |
| Sampling Plan | None (all index children in each cohort will be included) |
| Special Considerations | Home visitors are trained to use the Ages and Stages Questionnaire. |
| Data Collection | Data will be collected and entered into the home visiting database. |

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| Data Analysis Plan | <p>Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> <p>Index children screened by the ASQ in each cohort; enrollment in each year of the program; age of index child: ASQ Tool (12 month, etc.); index children who are screened and identified as below the cutoff score of 15.64 in the Communication section of the ASQ at 12 months who are referred and evaluated for additional services in cohort 1; index children who are screened and identified as below the cutoff score of 15.64 in the Communication section of the ASQ at 12 months who are referred and evaluated for additional services in cohort 2.</p> <p>The calculation will be determined comparing each cohort (cohort 1 and cohort 2) by dividing the total number of index children in each cohort (cohort 1 and cohort 2) who are screened and identified as below the cutoff score of 15.64 in the Communication section of the ASQ at 12 months of age who are referred and evaluated for additional services by the total number of index children screened in the Communication section of the ASQ that scored below the cutoff score of 15.64 at 12 months of age. The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts.</p> |
| Child's general cognitive skills | |
| Proposed Indicator | Index children screened in Problem Solving as measured by the Ages and Stages Questionnaire and referred and evaluated as appropriate |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of index children who screened below the cutoff score of 27.32 in the Problem Solving section of the ASQ at 12 months who are referred and evaluated comparing cohort 1 to cohort 2. |
| Measurement Tool | Ages and Stages Questionnaire (ASQ) |
| Validity of Tool | According to the developers, the ASQ has been extensively evaluated for reliability and validity. The ASQ has been found to be a reliable and valid tool for measuring children's performance in five developmental domains. Combined findings across years indicate overall agreement across questionnaires to be 83 percent (Squires, Potter & Bricker, 1999). Cutoff points were derived by subtracting 2 standard deviations from the mean for each area of development. Scores will be documented on the scoring sheet that accompanies the Ages and Stages Questionnaire. For families enrolled in Nurse-Family Partnership, ASQ scores will also be documented on the Infant Health Care Form. |
| Population Assessed | Index children |
| Sampling Plan | None (all index children in each cohort will be included) |
| Special Considerations | Home visitors are trained to use the Ages and Stages Questionnaire. |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis | Cohorts will be used to collect meaningful data for this construct. Index children who |

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| Plan | <p>mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> <p>Index children screened by the ASQ in each cohort; enrollment in each year of the program; age of index child: ASQ Tool (12 month, etc.); index children who are screened and identified as below the cutoff score of 27.32 in the Problem Solving section of the ASQ at 12 months who are referred and evaluated for additional services in cohort 1; index children who are screened and identified as below the cutoff score of 27.32 in the Problem Solving section of the ASQ at 12 months who are referred and evaluated for additional services in cohort 2.</p> <p>The calculation will be determined comparing each cohort (cohort 1 and cohort 2) by dividing the total number of index children in each cohort (cohort 1 and cohort 2) who are screened and identified as below the cutoff score of 27.32 in the Problem Solving section of the ASQ at 12 months of age who are referred and evaluated for additional services by the total number of index children screened in the Problem Solving section of the ASQ that scored below the cutoff score of 27.32 at 12 months of age. The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts.</p> |
| Child's positive approach to learning, including attention | |
| Proposed Indicator | Index children screened in child's positive approach to learning, including attention as measured by the Ages and Stages Questionnaire: SE and referred and evaluated as appropriate |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of index children identified as above the cutoff score of 48 of the total Ages and Stages Questionnaire: SE, at 12 months who are referred and evaluated comparing cohort 1 to cohort 2. |
| Measurement Tool | <p>Ages and Stages Questionnaire: SE</p> <p>The ASQ: SE was created in response to feedback from the ASQ for a tool to focus on children's social and emotional behavior. Scores will be documented on the scoring sheet that accompanies the Ages and Stages Questionnaire. For families enrolled in Nurse-Family Partnership, ASQ scores will also be documented on the Infant Health Care Form.</p> |
| Validity of Tool | The ASQ: SE is a parent-completed questionnaire to assess children's social-emotional development. The ASQ: SE was standardized on 3,014 children. Reliability Test-retest reliability was 94% and internal consistency ranged from 67- 91%. Validity Concurrent validity ranged from 81- 95%. |
| Population Assessed | Index children |
| Sampling Plan | None (all index children in each cohort will be included) |
| Special Considerations | Home visitors are trained to use the Ages and Stages Questionnaire. |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | <p>Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> <p>Index children screened by the ASQ: SE in each cohort; enrollment in each year of the program; age of index child: ASQ: SE Tool (12 month, etc.); index children who are</p> |

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| | <p>screened and identified as above the cutoff score of 48 of the total ASQ: SE at 12 months who are referred and evaluated for additional services in cohort 1; index children who are screened and identified as above the cutoff score of 48 of the total ASQ: SE at 12 months who are referred and evaluated for additional services in cohort 2.</p> <p>The calculation will be determined comparing each cohort (cohort 1 and cohort 2) by dividing the total number of index children in each cohort (cohort 1 and cohort 2) who are screened and identified as above the cutoff score of 48 of the total ASQ: SE score at 12 months of age who are referred and evaluated for additional services by the total number of index children screened in the total ASQ: SE that scored above the cutoff score of 48 at 12 months of age. The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts.</p> |
| Child's social behavior, emotion regulation and emotional well-being | |
| Proposed Indicator | Index children screened in social behavior, emotion regulation, and emotional well-being as measured by the Ages and Stages Questionnaire: SE and referred and evaluated as appropriate |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of index children identified as above the cutoff score of 48 of the total Ages and Stages Questionnaire: SE, at 12 months who are referred and evaluated comparing cohort 1 to cohort 2. |
| Measurement Tool | <p>Ages and Stages Questionnaire: SE</p> <p>The ASQ: SE was created in response to feedback from the ASQ for a tool to focus on children's social and emotional behavior. Scores will be documented on the scoring sheet that accompanies the Ages and Stages Questionnaire. For families enrolled in Nurse-Family Partnership, ASQ scores will also be documented on the Infant Health Care Form.</p> |
| Validity of Tool | The ASQ: SE is a parent-completed questionnaire to assess children's social-emotional development. The ASQ: SE was standardized on 3,014 children. Reliability Test-retest reliability was 94% and internal consistency ranged from 67- 91%. Validity Concurrent validity ranged from 81- 95%. |
| Population Assessed | Index children |
| Sampling Plan | None (all index children in each cohort will be included) |
| Special Considerations | Home visitors are trained to use the Ages and Stages Questionnaire. |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | <p>Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> <p>Index children screened by the ASQ: SE in each cohort; enrollment in each year of the program; age of index child: ASQ: SE Tool (12 month, etc.); index children who are screened and identified as above the cutoff score of 48 of the total ASQ: SE at 12 months who are referred and evaluated for additional services in cohort 1; index children who are screened and identified as above the cutoff score of 48 of the total ASQ: SE at 12 months who are referred and evaluated for additional services in cohort 2.</p> <p>The calculation will be determined comparing each cohort (cohort 1 and cohort 2) by</p> |

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| | dividing the total number of index children in each cohort (cohort 1 and cohort 2) who are screened and identified as above the cutoff score of 48 of the total ASQ: SE score at 12 months of age who are referred and evaluated for additional services by the total number of index children screened in the total ASQ: SE that scored above the cutoff score of 48 at 12 months of age. The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the difference in percentage between the two cohorts. |
| Child's physical health and development | |
| Proposed Indicator | Index children screened in Gross Motor and Fine Motor skills as measured by the Ages and Stages Questionnaire and referred as appropriate |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of index children who screened below the cutoff scores of 21.49 in both the Gross Motor and 34.50 in the Fine Motor sections of the ASQ at 12 months who are referred and evaluated comparing cohort 1 to cohort 2. |
| Measurement Tool | Ages and Stages Questionnaire (ASQ) |
| Validity of Tool | According to the developers, the ASQ has been extensively evaluated for reliability and validity. The ASQ has been found to be a reliable and valid tool for measuring children's performance in five developmental domains. Combined findings across years indicate overall agreement across questionnaires to be 83 percent (Squires, Potter & Bricker, 1999). Cutoff points were derived by subtracting 2 standard deviations from the mean for each area of development. Scores will be documented on the scoring sheet that accompanies the Ages and Stages Questionnaire. For families enrolled in Nurse-Family Partnership, ASQ scores will also be documented on the Infant Health Care Form. |
| Population Assessed | Index children |
| Sampling Plan | None (all index children in each cohort will be included) |
| Special Considerations | Home visitors are trained to use the Ages and Stages Questionnaire. |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | <p>Cohorts will be used to collect meaningful data for this construct. Index children who mothers/family enrolled in Year 1 of the program will be cohort 1. Index children who mothers/family enrolled in Year 2 of the program will be cohort 2. Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> <p>Index children screened by the ASQ in each cohort; enrollment in each year of the program; age of index child: ASQ Tool (12 month, etc.); index children who are screened and identified as below the cutoff score of 21.49 in both the Gross Motor and 34.50 in the Fine Motor section of the ASQ at 12 months who are referred and evaluated for additional services in cohort 1; index children who are screened and identified as below the cutoff score of 21.49 in both the Gross Motor and 34.50 in the Fine Motor section of the ASQ at 12 months who are referred and evaluated for additional services in cohort 2;</p> <p>The calculation will be determined comparing each cohort (cohort 1 and cohort 2) by dividing the total number of index children in each cohort (cohort 1 and cohort 2) who are screened and identified as below the cutoff score of 21.49 in both the Gross Motor and 34.50 in the Fine Motor section of the ASQ at 12 months of age who are referred and evaluated for additional services by the total number of index children screened in</p> |

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| | both the Gross Motor and Fine Motor section of the ASQ that scored below the cutoff scores of 21.49 and 34.50 at 12 months of age. The percentage in cohort 1 will then be compared to the percentage in cohort 2. The measurement will be the different in percentage between the two cohorts |
| Benchmark IV. Domestic Violence | |
| Screening for domestic violence | |
| Proposed Indicator | Percent of families that have been screened for domestic violence during the enrollment period |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain the percentage of enrolled families that have been screened for domestic violence during the enrollment period from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | <p>Structured interview questions recommended by the RI Coalition Against Domestic Violence. The following questions are used in community and hospital settings throughout Rhode Island.</p> <ul style="list-style-type: none"> • Is anyone close to you threatening or hurting you? • Is anyone close to you hitting, kicking, choking or hurting you physically? • Is anyone forcing you to do something sexually that you do not want to do? <p>Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. For families enrolled in Nurse-Family Partnership, supplemental information may be collected on the Relationship Assessment form.</p> |
| Validity of Tool | NA |
| Population Assessed | Families |
| Sampling Plan | None (all families will be included) |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | <p>Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria:</p> <p>Number of families screened for domestic violence.</p> <p>The calculation will be determined by dividing the number of families that have been screened for domestic violence during the enrollment period/Total number of enrolled families.</p> |
| Of families identified for presence of domestic violence, number of referrals made to relevant domestic violence services (shelters, food pantries) | |
| Proposed Indicator | Percent of families enrolled in the program identified with a presence of domestic violence that have been referred to relevant domestic violence services |
| Indicator Type | Process measure |
| Measurable Objective | Increase or maintain percent of referrals to relevant domestic violence services in families identified with the presence of domestic violence from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | For families with identified presence of domestic violence, referrals to relevant domestic violence services will be documented on a RI Maternal and Child Home Visiting form to be used across all three models and documented in the home visiting database. For families enrolled in Nurse-Family Partnership, supplemental information may also be collected on the Use of Government and Community Service form and entered into home visiting database. |
| Validity of Tool | NA |
| Population Assessed | Families |

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| Sampling Plan | None (all families will be included) |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Families screened for domestic violence (yes/no); Families who screen positive for presence of domestic violence; Referrals for families who screen positive for presence of domestic violence. The calculation will be determined by dividing the number of families that have been screened for domestic violence who were identified for presence of domestic violence and were referred to relevant domestic violence services by the total number of families identified with a presence of domestic violence. |
| Of families identified for presence of domestic violence, number of families with a safety plan completed | |
| Proposed Indicator | Percent of families enrolled in the program identified with a presence of domestic violence that have a safety plan completed |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase or maintain percent of families identified with the presence of domestic violence that have a safety plan completed from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Participant interview. Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. |
| Validity of Tool | NA |
| Population Assessed | Families |
| Sampling Plan | None (all families will be included) |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrollment from the start of the project period; Families screened for domestic violence (yes/no); Families who screen positive for presence of domestic violence; Families who screen positive for presence of domestic violence and have a safety plan completed. The calculation will be determined by dividing the number of families that have been screened for domestic violence who were identified for presence of domestic violence and have a safety plan completed by the total number of families identified with a presence of domestic violence. |
| Benchmark V. Family Economic Self-Sufficiency | |
| Household income and benefits | |
| Proposed Indicator | Percentage of enrolled families who increase their total amount of income from employment, income from public systems and/ or the value of in-kind benefits the family receives |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase the percentage of families who increase their total amount of income from employment, income from public benefits and/ or the value of in-kind benefits the family receives, within 1 Year post enrollment. |
| Measurement Tool | Structured interview questions with the enrolled family that captures estimated earnings from employment, income from public systems and the value of in-kind benefits the family receives. A total for each type of income (employment, public system, in-kind benefits) and the aggregate for all three sources will be documented. Questions and the format for capturing the data will be included on a Maternal and Child Home Visiting Employment, Education, Income and Benefits form to be used across all three models. |

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| | This information may also be collected on an Expanded Data Collection form for families enrolled in Nurse-Family Partnership. |
| Validity of Tool | NA |
| Population Assessed | Enrolled families |
| Sampling Plan | None (all families will be included) |
| Special Considerations | As part of the enrollment information collected from each family, home visitors will ask families to disclose income from employment, income from public systems and in-kind benefits the family receives. The same information will be collected again at one year post program enrollment. |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Aggregate monetary value of household income information (income from employment, public systems and in-kind benefits) received at time of enrollment and household income information at one year post enrollment The calculation will be determined by dividing the number of families who increase their aggregate household income from enrollment to one year post program enrollment by the total number of families enrolled in the program for a year. |
| Employment or education of adult members of the household | |
| Proposed Indicator | Percentage of mothers enrolled in the program that are not employed that participate in an educational program |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase or maintain the percentage of enrolled mothers that are not employed at time of program enrollment that participate in an educational program within 12 months post enrollment. An educational program is defined as high school/ GED, college classes, vocational/ trade/ job training and/ or English as a Second Language classes. Participation in an educational program is defined as a mother enrolled and actively attending and/ or involved in one of the above types of educational programs. |
| Measurement Tool | Structured interview questions with enrolled mothers that capture their employment and education status. The employment and education status of each mother will be documented. Questions and the format for capturing the data will be included on a Maternal and Child Home Visiting Employment, Education, Income and Benefits form to be used across all three models. This information may also be collected on an Expanded Data Collection and/ or Intake form for mothers enrolled in Nurse-Family Partnership. |
| Validity of Tool | NA |
| Population Assessed | Unemployed mothers |
| Sampling Plan | None (all enrolled, unemployed mothers will be included) |
| Data Collection | Data will be collected and entered into the home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Number of enrolled mothers in the program that are unemployed at time enrollment and their educational program participation at one year post enrollment. The calculation will be determined by dividing the number of unemployed mothers at time of program enrollment that are participating in an educational program families within one year post enrollment by the total number of enrolled mothers that were unemployed at time of enrollment. |
| Health Insurance Status | |

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| Proposed Indicator | Percentage of mothers and index children who obtain and/ or maintain health insurance within three months of program enrollment. |
| Indicator Type | Outcome Measure |
| Measurable Objective | Increase in the percentage of mothers and index children that obtain and/ or maintain health insurance within three months of program enrollment from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Standard interview question to determine status of health insurance |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at specific time points. At each visit, families will be asked about the mother's and index child's health insurance status; Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. Enrolled women will be asked if they have health insurance or have obtained health insurance since their last home visit; if enrolled woman has health insurance, she will be asked her insurance type. Enrolled women will be asked if their child has health insurance or has obtained health insurance since the last home visit; if child has health insurance, mother will be asked her insurance type. Home visitor will ask to see copy of insurance card(s). |
| Population Assessed | Enrolled mothers and index children |
| Sampling Plan | None (all enrolled mothers and index children will be included) |
| Special Considerations | Separate data will be collected for both maternal and child health insurance and aggregated for this construct |
| Data Collection | Data regarding maternal and child health insurance is collected at each visit, and entered into home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Enrolled mothers and index children in the program by insurance status; Enrollment from the start of the project period; Status of health insurance at three months post enrollment. The calculation will be determined by dividing the number of enrolled mothers and index children without health insurance who enrolled in a health insurance plan within three months of enrollment by the total number of enrolled mothers and index children who did not have health insurance at enrollment plus the number of enrolled mothers and index children that had health insurance at time of enrollment who maintained their health insurance plan at three months post enrollment by the total number of enrolled mothers and index children who health insurance at time of enrollment but did not have health insurance at three months post enrollment. |
| Benchmark VI. Coordination and Referrals for Other Community Resources and Supports Number of families identified for necessary services | |
| Proposed Indicator | Percent of families screened for necessary services. Necessary services include: <div style="display: flex; justify-content: space-between;"><div>Violence/ IPV</div><div>Cessation</div></div> <div style="display: flex; justify-content: space-around; margin-top: 10px;">Health Services Depression Developmental Delays and Benefits</div> <div style="display: flex; justify-content: space-around; margin-top: 10px;">____ Health Insurance Status ____ Education/ Employment</div> |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase or maintain in the percentage of families screened for necessary services from Year 1 baseline to Year 3 benchmark reporting period. Necessary services are defined as Domestic Violence/ Interpersonal Violence, Maternal Depression, Health Insurance Status, Tobacco Cessation, Developmental Delays, Education and Employment, |

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| | Mental Health Services, Income and Benefits. |
| Measurement Tool | Standard interview questions and/ or standardized tools dependent upon the type of service (PHQ-9 for Maternal Depression, ASQ-3, ASQ:SE for developmental delays) |
| Validity of Tool | Information is collected through skilled conversations with the families using semi-structured interview protocol administered at each home visit or at specific time points depending on the service. Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. For families enrolled in Nurse-Family Partnership, supplemental data will be collected on the Home Visit Encounter form. |
| Population Assessed | Enrolled families |
| Sampling Plan | None (all enrolled families will be included) |
| Data Collection | Data regarding screening for necessary services will be collected at each visit or at specific time points depending on the service and entered into home visiting database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Number of families screened for necessary services at appropriate intervals. The calculation will be determined by dividing the number of families screened for necessary services at the appropriate screening intervals for their enrollment period by the total number of families enrolled in the program. |
| Number of families that required services and received a referral to available community resources | |
| Proposed Indicator | Percent of families identified with an identified need that received an appropriate referral, when there were services available in the community |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase or maintain in the percent of families with an identified need that received an appropriate referral, when there were services available in the community from Year 1 baseline to Year 3 benchmark reporting period. An identified need is defined as domestic violence/ interpersonal violence services, maternal depression treatment services, health insurance, tobacco cessation services, services to address developmental delays, education and employment services, mental health services, services to increase income and benefits. |
| Measurement Tool | None |
| Validity of Tool | Referrals to services will be documented. Data will be collected on a RI Maternal and Child Home Visiting form to be used across all three models. For families enrolled in Nurse-Family Partnership, supplemental data will be collected on the Home Visit Encounter form. |
| Population Assessed | Enrolled families |
| Sampling Plan | None (all enrolled families will be included) |
| Data Collection | Data about referrals will be collected at each home visit and entered into the database. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Number of families identified/ screened for necessary services; Number of families with specific identified need(s) that received an appropriate referral to an available service. The calculation will be determined by dividing the number of families screened for necessary services with identified need(s) as defined above that received an appropriate referral/Total number of families screened for necessary services with an identified need (as defined above). |
| Number of Memoranda of Understanding or other formal agreements with other social | |

| service agencies in the community | |
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| Proposed Indicator | Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community. |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase or maintain the number of Memoranda of Understanding or other formal agreements with other social service agencies in the community from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Home Visiting Agency Administrative Records/ HEALTH Administrative Records |
| Validity of Tool | NA |
| Population Assessed | Home Visiting Agencies |
| Sampling Plan | None (all certified home visiting agencies will be included) |
| Data Collection | The number of Memoranda of Understanding or other formal agreements will be collected quarterly from home visiting agencies. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below: Number of Memoranda of Understanding or other formal agreements at Year 1 baseline; Number of Memoranda of Understanding or other formal agreements at Year Three of program. |
| Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies | |
| Proposed Indicator | Number of social service agencies that have a regular communication with home visitor provider, with clear point of contact and regular sharing of information between agencies. |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase in the number of social service agencies that have regular communication with home visitor provider, with clear point of contact and regular sharing of information between agencies from Year 1 baseline to Year 3 benchmark reporting period. |
| Measurement Tool | Home Visiting Agency Administrative Records/ HEALTH Administrative Records/ Local Implementation Team Meeting Minutes |
| Validity of Tool | NA |
| Population Assessed | Home Visiting Agencies |
| Sampling Plan | None (all certified home visiting agencies will be included) |
| Data Collection | The number of social agencies that have a clear point of contact and regularly share information will be collected quarterly from home visiting agencies and during Local Implementation Team Meetings. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below: Number of social service agencies with clear point of contact at baseline; Number of social service agencies with clear point of contact at Year Three of program |
| Number of completed referrals | |
| Proposed Indicator | Percent of families enrolled in the program with referrals where receipt of referrals can be confirmed |
| Indicator Type | Outcome measure |
| Measurable Objective | Increase the percent of families enrolled in the program with referrals for necessary services where receipt of referrals can be confirmed from Year 1 baseline to Year 3 benchmark reporting period. An identified need is defined as domestic violence/ interpersonal violence services, maternal depression treatment services, health |

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| | insurance, tobacco cessation services, services to address developmental delays including Early Intervention, education and employment services, mental health services, services to increase income and benefits, including TAN F, WIC and SNAP. |
| Measurement Tool | Client self report and/ or home visiting and HEALTH administrative records. Families will be asked about the status of referrals using a semi-structured interview protocol and documented on a RI Maternal and Child Home Visiting form and/ or Maternal and Child Home Visiting Employment, Education, Income and Benefits form. This information may also be collected on an Expanded Data Collection form for mothers enrolled in Nurse-Family Partnership. Home visiting and HEALTH administrative records will support the confirmation of referrals. |
| Validity of Tool | NA |
| Population Assessed | Enrolled families |
| Sampling Plan | None (all enrolled families will be included) |
| Data Collection | Data about families referred for services will be collected at every home visit and entered into the home visiting database. KIDSNET, the Rhode Island Department of Health's confidential, computerized child health information system, tracks receipt of referral for some services including Early Intervention and WIC and will be used to support the receipt of referrals for families enrolled in Maternal, Infant and Early Childhood Home Visiting Programs. |
| Data Analysis Plan | Data will be reviewed quarterly by the metrics below based on a data system query using the following criteria: Number of families referred for services; Number of families with receipt of referrals for services (as defined above) where receipt of services can be confirmed. |